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NOW & THEN

THE APPALACHIAN MAGAZINE

THE CENTER FOR APPALACHIAN STUDIES AND SERVICES • EAST TENNESSEE STATE UNIVERSITY

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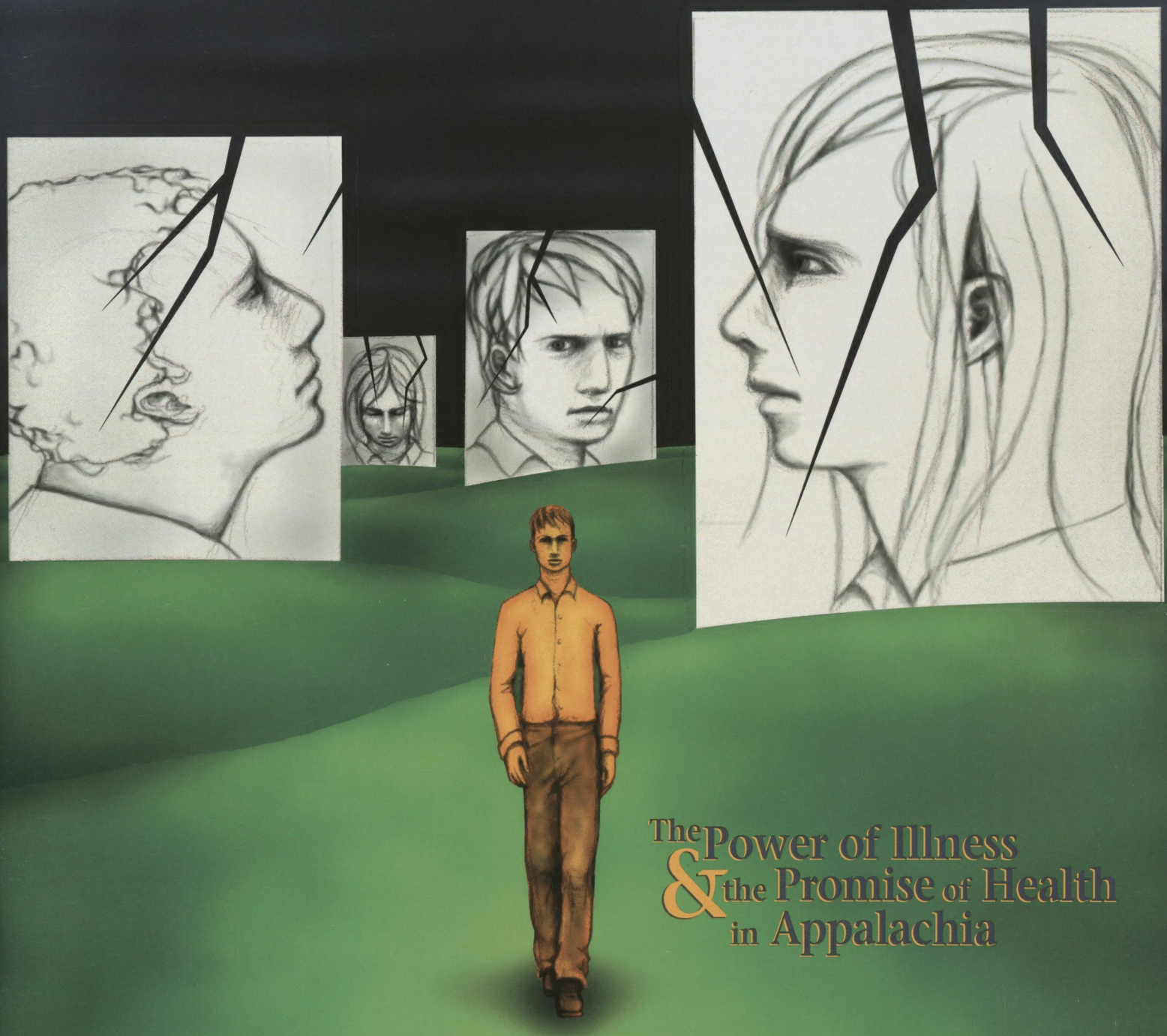

The Power of Illness & the Promise of Health in Appalachia

After a Near-Death Experience

yes, she sings in the church of her bones, none
of them broken, though all are being whittled by time, that
expert carver who leaves nothing
untouched, yes, she praises the paradigm of skin that
appears only to conceal what goes
on under the surface (though at times
you can catch a glimpse in the dark when her body
melts and her pupil grows large—like the rim
of a well you look over, and for a split second, you
see a flash powder the bottom, though it
could be your own image), yes, she revels in the incense
of flesh, the pip of her lungs, the pumped-up organ
of her heart, yes, its music of iron has secret red springs
that thread the continental map of her blue veins, each cell's
base rhythm, distinct as a wound, yes, she bends
her willowy spine, jointed to serve whether she
walks or sits down, like now, its nerves, finely tuned
as a NASA countdown, fire off rockets to her brain—that noisy cloud
cradling the skull whose nose and ear holes, whose sockets
have been molded by an artist who loves to work
with his hands—that cloud now clearing to blue sky,
her lips curve like a crescent moon above
the Alpine slope of her shoulders running down
to snowy arms to hands that join forefingers
to thumbs and rest their zeros
on the lotus of her legs,
its creamy petals.

—Llewellyn McKernan

Llewellyn McKernan, who lives in Barboursville, W.Va., has had several brushes with death that have made her want to celebrate life and the human body. She has recently had a poem accepted by Kalliope *for their prose-poem issue.*

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Spring 2000
Volume 17, Number 1

NOW & THEN
THE APPALACHIAN MAGAZINE

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Every Saturday twilight reminds me:
Anything can be broken.
Every morning I wake,
each bone singing some new song.

—Donna Doyle

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An Uneasy But Glorious Alliance

Every once and awhile, you'll look down at my house and see a used syringe or a bloodstained test strip that hasn't quite made it to the trash can. It's all become just part of the landscape ever since one of my sons was diagnosed with juvenile diabetes almost four years ago.

When managing editor Nancy Fischman and I first embarked on this venture, we thought of this as the "health care" issue. But that isn't quite the way it turned out. In part, every issue has a life of its own, shaped by the submissions which intrigue us. I must admit, though, that pieces about living with illness probably had better than average odds of speaking to both Nancy and myself. I spend a part of each day helping my 13-year-old son cope with an incurable disorder, and Nancy grew up watching her father become increasingly debilitated and finally die from the complications of multiple sclerosis. And so this *Now & Then* is as much about the power of illness as it is about the promise of health.

Of course, it's not that this issue doesn't have plenty to say about health care, especially the practice of medicine in rural areas. Appalachia, after all, is more rural than urban; attracting and keeping health care professionals in the region's small towns and countryside is a pressing and ongoing problem.

But it's a problem Appalachians are addressing. With the help of the Kellogg Foundation, East Tennessee State University in Johnson City, Tenn., has begun training primary care health professionals in interdisciplinary teams in the very communities where they're needed most (p. 20). And both the University of Tennessee Telemedicine Network and the Appal-Link Network in Cedar Bluff, Va., are devising imaginative ways to use technology to simulate face-to-face visits with the doctor so that people can receive care without having to travel long distances (p. 26).

Last fall, I spoke to a public health class where a student was working on a problem in a nearby county: A substantial number of women weren't seeking prenatal care. When the student spoke to expectant mothers, they told her they weren't quite sure what the fuss was about. Their mothers and grandmothers had had fine, healthy babies without going to the doctor before delivery. So the student found herself trying to solve a problem—a real problem—that her target population didn't know it had. It wasn't going very well, she sighed.

In contrast, two of the health care initiatives described in this issue start out by really listening to people. In Western North Carolina, the Madison County Health Coalition (p. 16) began its attempts to improve the community's health by doing no less than 40 group interviews. Again with help from Kellogg and with participation from anyone interested in helping out, the coalition then planned and executed projects that directly addressed community concerns. Once the group earned the community's trust, it could move on to other health issues. Michael G. Meyer of Toborg Associates Inc. describes his research firm's work for the National Cancer Institute (p. 25). It also knows it needs to understand Appalachian beliefs and values before it can hope to enlist the aid of the region's women in the campaign against tobacco use. So in Appalachia, the promise of improving health care is very real.

But so too is the power of illness. There are stories and poems here by people whose lives have been shattered by injury and disease. They have been attacked by polio viruses, by snakes, by cars driven by drunk drivers, and by cancer. They are living despite the betrayal of their own bodies as those bodies set out to destroy their muscles, brain cells, or the ability to produce insulin so their cells can receive the energy they need to sustain life. These people fight frustration and despair, they adapt and survive, they succumb or they heal. Their loved ones stand by—not always knowing what to do, doing the best they can.

"Anything can be broken," writes poet Donna Doyle in "After the Wreck" (p. 37) about her recuperation from a head-on collision. The remarkable thing is not how frequently the human body fends off attacks but how often recovery is possible and how facing mortality helps us treasure life. "Every morning I wake," says Doyle, "each bone singing some new song." The stories found in these pages about the uneasy but glorious alliance we forge with our own bodies belong to us all.

—Jane Harris Woodside, Editor

Letters to the editor should be sent with the writer's name, address, and daytime phone number to: Editor, Now & Then, *ETSU, Box 70556, Johnson City TN 37614 or e-mail woodsidj@etsu.edu. Letters may be edited for length and clarity before publication.*

Tonic

Bitterroot herb that grows
by spring water, peeled of bark,
is yeller. Its gall chewed
soothes a mouth sore. Now,
'sang cures most thangs. A tangle
of lady's slipper slowly seeped
calms the shakes. Goldenseal
heals the broken heart. The 'shine
in the Mason jar made murky
as stump water confronts science.
Macerated roots and liquor turn
in tinctures of folk remedies.
Her wrinkled hands don't shake.
A perfect spoon is poured.
"Swallow it quick, but no more."
Without doubt, I trust wisdom.

—John Cantey Knight

In 1996, New Delta Review *awarded John Cantey Knight the Eyster Prize for Poetry. Between 1997 and 1999, he received four* Amelia Magazine *poetry awards. His work has been published in numerous magazines, including* Black Buzzard Review, CER*BER*US, Struggle, ZZZ ZYNE, *and* Now & Then.

A Correction

There were two mistakes in the spring 1999 Appalachian Architecture article "Invershiel: A New Old World in the Blue Ridge Mountains." The authors attributed a quote to "historian Celeste R. Ray." Her name is actually R. Celeste Ray, and she is an anthropologist. We apologize for the error.

In Isolation

By William E. Wallace

Separated from home and family, a young West Virginia boy negotiates the eerie world of a polio sanitarium.

The last day of elementary school before Christmas vacation always had little to do with education—and was definitely not to be missed. But on that particular day in 1952, I returned to my Charleston, W.Va., home from my 6th grade classroom at noon.

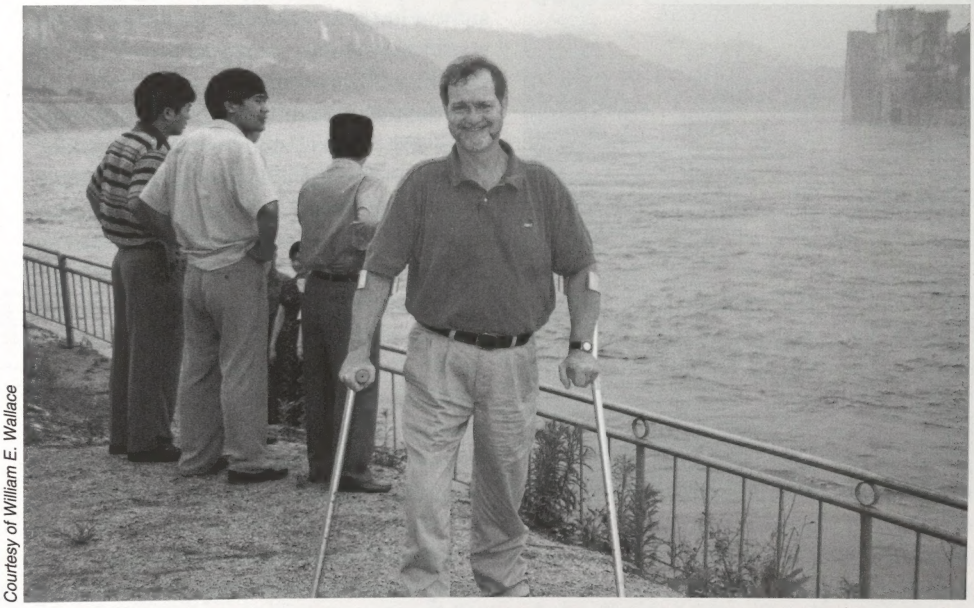
At first, we thought it was a cold, then perhaps the flu. After a few days, the doctor speculated it was yellow jaundice. One evening, Grandmother Wallace applied an onion poultice to my chest, but even that warm therapy did not cure or clarify my condition.

On the third day before Christmas, I was awakened by the telephone ringing. I answered it and returned to bed. Later there was another call, and as I stepped from bed, I noticed I had to touch the wall lightly. Later there was yet another call, and this time, I had to place the palm of my hand against the wall to steady myself against a mild but growing dizziness. It progressed through the day as I lay on the couch and watched the fire.

That evening, when called for supper, I stood—and fell, but I painstakingly got up and went to the family evening meal. As I stood up at the end of supper, my knees buckled and I again fell. I self-consciously excused myself and carefully returned to the living room.

The family was going to visit an aunt and uncle later in the evening to exchange presents. Mother called from upstairs telling me to come up. I went to the foot of the stairs, put my hand on the newel post to start up—and stopped. I intended to go upstairs. I told myself to go up the stairs, but something stopped me. I stood at the foot of the stairs in the dark for some time.

Mother eventually came into the light at the top, stood, and then asked, "Why aren't you coming up?" I didn't know what to say except, "I think I'd better not try to come up the stairs." Mother didn't



Courtesy of William E. Wallace

Bill Wallace visited the Three Gorges dam project on the Yang-Tze River in China in July 1998. He is collaborating on a study of silicosis with Chinese colleagues from Tongji Medical University, Wuhan.

move, and the silence drew my father.

When the doctor arrived a few hours later, they stood me up from the couch in front of the fire to walk, my last attempt to take an unassisted step for many years. They all went into the kitchen, then Daddy returned. "Bill, the doctor thinks you have polio," he said. I told my father, "I know."

They let me stay at home that winter solstice night. In the morning, I could not sit up, and I could not roll over to my side. They took me to Charleston General Hospital for a spinal tap, and then they took me up the Kanawha River to the little town of Marmet.

The Kanawha River is actually a downstream, slightly wandering part of the New River which rises in North Carolina, flows through Virginia, and into West Virginia. There are angular hills and long, low ridge mountains in this state, but no broad valleys. Whenever my Grandmother Wallace and the family would drive upriver to visit her mother, she would say, as we passed through the narrow cleft of Marmet, "Look up there! That's where they keep the infantile paralysis children." I could never spot the dreaded institution from the moving car.

The Marmet polio hospital was an old public grade school converted into a hospital in the midst of the epidemic. Two new wings had been added to the old square two-story building. One was a long corridor with separate cubicles containing the iron lungs. The last room at the end of the corridor was the isolation room.

Courtesy of William E. Wallace

On visiting day, parents would come in masked against the possibility of contracting the polio virus. Wallace had access to a wheelchair on this day as his picture was taken in front of a ward-mate and the boy's parents.

When the doctor arrived a few hours later, they stood me up from the couch to walk, my last attempt to take an unassisted step for many years.

They usually put you in "isolation" for one week upon entry into the sanitarium to make sure you didn't bring in other childhood diseases, to let the polio virus run its course, and to let you die—if it came to that. Lying flat on my back in the isolation room, I could roll my head from side to side, and I could lift my arms—and that was all. Still, I was not in an iron lung. I slipped in and out of consciousness. On Christmas night, my parents came to my window outside of the hospital and stood in the snow until the hospital staff saw them and made them leave.

There is love, even at the end of the world, at the edge of the earth. At night when I would cry, a young girl in an iron lung, invisible in the next cubicle, would soothe me, speaking across the wall in a tidal rhythm.

The masked nurses and orderlies measured my "intake" and "output" of fluids. Once I was mortified to awaken and find myself in a warm dark pool, which was dutifully poured, scraped, and measured.

Research would find that fecal matter was one of the primary vectors for transmission of the disease. The nurses and orderlies, their courage never acknowledged, knowingly placed themselves at risk of contracting the virulent illness as they performed the most humble of tasks during the course of their daily care of the patients.

One day, a kind nurse offered to lift me up to see the snow. My head was not a foot above the bed when the world exploded. The muscles, receiving no stimuli from dead or dying motor nerves, spasm, and the limbs become as stiff as rigor mortis, bending only with tearing pain. The hospital staff extended my stay in isolation to a second week. My mother told me years later that she had been informed that I was continuing to sink.

Finally after two weeks, when it appeared I would not distress the others with an untimely demise, they moved me into the boys' ward. There were about a dozen of us, ranging from grade school to junior high age, with various degrees of disability. During my first couple of months there, I was the worst off, except for maybe Johnny Duncan. But he at least had his braces.

Getting your braces was a big event: It meant that you were restored to some level of mobility. We were too young to realize that it also meant that you had roughly reached the upper limits of possible improvement. After the acute viral infection had passed, some damaged motor nerves might rebound and return function to their muscles. But there was and is no therapy for the killed nerves, no cure for the residual paralysis.

Johnny Duncan's braces started at his heels, ran up both legs, over his hips, up his spine, across his shoulders, up his neck, and then finally out his locked, outstretched arms. There was a girdle to hold his guts in. The nurses and orderlies would lock all the joints in the braces, loft him up like a crucifix to his feet, and

One day, a kind nurse offered to lift me up to see the snow. My head was not a foot above the bed when the world exploded.

totter him in an unstable equilibrium across the ward. Looking back now from my subsequent experiences of being propped on leg braces and crutches above the shining, slick, hard, and shattering floor, I can imagine, I can taste his terror at the thought of a slip by the orderly, the consequent fall of the stiff, uncontrolled body, pitching forward with no arms to protect the rigidly held face from the uprushing tile floor. Perhaps he imagined himself a knight in armor, lance in hand,

Courtesy of William E. Wallace

Wallace (l) sits with two other patients and an orderly at the Marmet hospital. Getting your braces was a greatly anticipated milestone.

fixed upon a horse. I don't know. I don't remember his ever telling me much.

Initially I was at the bottom of the social order with Johnny. There was a pecking order based on age, maneuverability, strength, powerlust, and meanness of spirit or whatever makes some seek an administrative position. Our Caesar was Klempner. Say the name, *Klempner,* and see him. He was the eldest, perhaps a ninth-grader, and walked with only a slight limp. He was as concerned with his dominion as any Italian prince.

He introduced himself to me early on, coming to the side of my bed when the doctors had long gone and the nurses temporarily scattered. I looked up from my frozen flat reclining position to watch him heft his carcass into the air up on his hands, hovering over me. Then, with a furtive glance over his shoulder to make sure no one was watching, he'd drop his weight onto my chest, again and again and again. After I couldn't breathe or if a nurse or orderly appeared from the hall, he would shake me gently. "Billy, Billy… Are you OK?" So solicitous: He'd pause, smile, and then wink. "I'll come back and see you again later."

Second in command was Joel, who found himself caught in the classic quandary of a liberal bound to serve a malign master: He hated himself, but he followed orders. He had no choice. Klempner practiced on my quiescent bones the methods he employed to control Joel. There is a way you can close a finger into an apparently normal folded position and then continue to squeeze down and in, past the flexibility of the joint. Joel noted that he had seen paralyzed boys literally flip off the bed in response to Klempner's manipulations.

By the time I was mobile enough to be able to handle a wheelchair, the little girl whose voice had sustained me during my two weeks of isolation was able to be out of her iron lung for extended periods of time. In all honesty, I had pretty much forgotten about her. But on occasion, the boys and girls would be together in the schoolroom, and she would turn to me with a shy smile. It was absolutely critical to avoid the ward boys' ridicule, so I wouldn't deign to smile, even to look straight at her. The boys picked up on the slightest nuance, however, and directed leering smiles at both of us during these schoolroom meetings. She was sensitive enough to see and accommodate my predicament. She never spoke.

At one of these get-togethers, the staff gave us cardboard and crayons to make and exchange valentines. The little girl had a nurse surreptitiously deliver to me a card she had made. I, of course, would not reciprocate. So, with a sick feeling, I saw her, all aglow, begin to open a card which she clearly presumed to be from me. But half-a-dozen pairs of eyes were also on us, that is when they weren't exchanging knowing looks among themselves. One of the boys rolled up to me and whispered, "It says: 'Roses are red, violets are blue, sugar is sweet, and you are fat!'"

I watched, horrified but not protesting, as across the room, she opened the card, bent forward, and lowered her head. I didn't say a word to her or complain to the boys. She and I shared nothing else.

April brings the spirit of spring, even to a polio ward. We boys were full of ourselves one Sunday afternoon, just after the regular weekend visiting hour when we'd gotten to see our parents. Each week, I would beg Mother and Daddy to pull their masks back when the nurses weren't looking so I could see their faces. Mother would determine the location of the nurses and carefully oblige.

Klempner had gone. He had been fitted with a short leg brace and released back into the outside world. In the world within the ward, we were enjoying the benign reign of Joel.

Joel proclaimed a spring spree: We clapped and yelled and threw paper from our beds all over the ward. The nurses and orderlies recognized the frail traces of health in the event and let it proceed. But when I threw a jigsaw puzzle to the ceiling, it was too much for a lovely but vacuous red-haired nurse. She had earlier gained my enmity by hesitating to bring me urinals after I had defeated Klempner in a water-drinking contest which had involved 40-odd trips by Joel with Dixie cups from the hall fountain to my bed. Now there was a confrontation, and, unable to best a 10-year-old verbally, she said, "All right for you, Mr. Smarty. We'll see how smart you are!"

Upstairs was a dark hall and a set of four large rooms. Into one of the empty rooms, my beauty had me carried. For some reason, the vacant upstairs ward was subdivided into separate bed-sized cells. She left me in one, closing first the cell door and then the ward door. I was still a long way from being able to stand, but there was a nurse in the hall to whom I could call for water or a urinal or a bedpan. Meals were brought to me.

She summoned an orderly that night to carry me out of the cell and back into the luminous world of my friends. The boys all cheered. My return was sweet beyond telling.

I hadn't realized how much the companionship of the ward, such as it was, had meant to me. I was taken daily to physical therapy or "P.T."—we boys joked that it stood for "pain and torture." The initial job in P.T. was to break loose the stiff muscles by means of an often excruciating process called "stretching." Later there was ongoing electrical stimulation therapy to delay the inevitable atrophy of the de-enervated muscles, using an

Courtesy of William E. Wallace

Wallace was able to return home from the Marmet hospital after six months, in June 1953.

early and very unpleasant version of electromyography. But by midweek, I was actually hungering for P.T., just to catch a glimpse of my friends.

The beautiful one came to accept my abject apologies. I couldn't resist the opportunity to best her again. And so, once again, "All right for you, Mr. Smarty!"

I continued in isolation. Amazingly, when I returned from P.T. one day, there was a yellow balloon on the bed. I spent hours carefully rubbing it on the blanket, using static electricity to stick it to the wall beside the bed, watching it slowly descend as it lost its charge. Was the balloon a peace offering? Or was it encouragement from a secret friend? It didn't matter: I was stubbornly caught up in mad rebellion and testing the wages of sin. But the daylight, streaming horizontally up above the top of the cell partition, seemed distant.

By Friday night, I broke. I broke in part from loneliness, in part from the shame of having my parents come the next day to find me in isolation. It didn't occur to me that the beautiful one was also not looking forward to that event. So unlike Luther, I recanted. I sang of the beautiful but vacuous one's wit and propriety.

She summoned an orderly that night to carry me out of the cell, out of the ward, past the nurse sitting in the circle of light at a desk in the upstairs hall, down the dark stairs, and back into the luminous world of my friends. The boys all cheered. My return was sweet beyond telling. My God, so few things in life have given me such relief and joy.

That night there was still a nurse stationed in the dark upstairs hall outside what had been my personal isolation cell. A nurse was always stationed there because there was another boy upstairs, confined alone, in a large, quiet ward across the hall from the place of my punishment. He was there when I came, and he was there when I left. His sin?

The year is 1953. In another year, the United States Supreme Court will consider the case of Brown vs. the Board of Education of Topeka, Kansas, attempting to end racial segregation in our schools—and to end the isolation of people in our midst. But not yet. Not yet. N&T

Excerpted from "In Isolation" © Copyright by William E. Wallace, 2000.

William E. Wallace and his wife Elisabeth live in Morgantown, W.Va. They have two children, Sarah and David. He is a Ph.D. research physicist and leader of the Molecular Biophysics Team at the U.S. National Institute for Occupational Safety and Health, studying coal workers' pneumoconiosis and other occupational diseases.

Polio

Essayist William E. Wallace has the dubious distinction of having been part of a banner year for polio epidemics. In 1952, the year he contracted the disease, the incidence of poliomyelitis in the U.S. peaked at 57,600 cases, an all-time high up 73 percent from 33,344 cases only two years before in 1950.

Polio, or infantile paralysis, is a highly contagious infection that can, in its most severe manifestation, lead to paralysis or death. Caused by three closely related viruses, the ailment strikes young adults and, especially, children. Infected individuals spread the viruses that cause polio through their waste or saliva. Once the microbes enter the body, they reproduce in the intestines, then spread into the central nervous system where they damage or kill off nerve cells.

The illness afflicted humans for hundreds, perhaps thousands of years before it achieved epidemic proportions during the late 19th and the first half of the 20th centuries. The earliest outbreaks were reported in Sweden in the late 1880s, while New York City endured the first major U.S. epidemic in 1916. Before long, each summer saw the crippling disease ravage some part of the country, usually an urban area. The worst period of epidemics in the U.S. extended from 1942—just before the construction described in "The Grit Behind the Miracle" (p. 8) by Alice E. Sink of the Hickory Emergency Infantile Paralysis Hospital in North Carolina—until 1953, at approximately the same time Wallace was a patient in the Marmet, W.Va., polio sanitarium.

Polio epidemics, it turns out, were the completely unintentional byproduct of one of public health's greatest victories: dramatically improved sanitation. During the era of poor sanitation, most babies were exposed to polio early on, at a time in their lives when they were likely to come down with only a mild, often imperceptible case. Such exposure during infancy granted them a lifelong immunity.

As the 20th century progressed, many older children and young adults were exposed to polio viruses and had no antibodies in place to fight them, resulting in a much more serious illness. Still, only a very small percentage of all infected individuals developed the paralytic form of the malady. In the vast majority of instances, the afflicted person either experienced no symptoms at all or took sick with a relatively mild, flu-like illness.

Those unlucky few who suffered from paralytic polio, however, faced the risk of death or a lifetime of varying degrees of disability. The type of damage that paralytic polio left behind depended on what part of the central nervous system the virus attacked. If certain nerves in the spinal cord were invaded, the person developed a weakness in his or her limbs, most often the legs. Sometimes the debility passed. Other times, the victim emerged with a limp, or needing braces and crutches, or confined to a wheelchair. If the nerves in the upper spine controlling the diaphragm were harmed, the person had difficulty breathing and required temporary or permanent mechanical assistance with respiration. If the viruses destroyed motor nerves near the brain stem, the region regulating crucial involuntary actions, the individual could not swallow or talk. Secretions that pooled in the throat could block the airway, causing suffocation.

Wallace missed by less than a year and a half the introduction of the Salk vaccine that precipitated the dramatic decline in polio in the U.S. and the world. Salk, a physician and epidemiologist, had tested a vaccine during the spring of 1952, just months before William Wallace fell ill. Administered by injection, the vaccine consisted of inactive viruses that could not reproduce but were capable of eliciting the production of antibodies. While Salk's vaccine was very safe, some doubted its ability to confer permanent immunity. After further field-testing in 1954, the Salk vaccine was released for use on April 12, 1955, the 10th anniversary of the death of the most famous polio victim of all, President Franklin D. Roosevelt.

In the early 1960s, virologist Albert Sabin's orally administered vaccine made of live but weakened virus was approved for use. While it conferred permanent protection, recipients of Sabin's vaccine ran an extremely slight but real risk of contracting the very disease it was designed to prevent. Until recently, the Centers for Disease Control and Prevention (CDC) recommended a combination of both the Salk and Sabin vaccines: Salk's vaccine gives the person at least the temporary ability to fight off the polio, making it safer to administer Sabin's live virus vaccine conferring permanent protection.

As of this past January, the CDC and the American Academy of Pediatrics now recommend the exclusive use of an updated, stronger version of the Salk vaccine, ending nearly 40 years of dispensing the Sabin vaccine. The live virus in the Sabin vaccine causes eight to 10 cases of polio a year in the U.S. Improvements in the Salk vaccine combined with the minuscule risks of a polio epidemic in the U.S. today mean that the risks of the oral vaccine now outweigh its benefits.

Unfortunately, by the early 1980s, it became apparent that this virulent disease had not finished taking its toll. Post-polio syndrome (PPS), a condition affecting somewhere between 20 and 40 percent of the 1.63 million American polio survivors, can make its presence known anywhere from 10 to 40 years after the initial attack. Although the condition is rarely life-threatening, those suffering from PPS live with symptoms ranging from fatigue, intolerance to cold, and painful joints and muscles, to difficulty breathing and swallowing and slowly progressive muscle weakness and atrophy. Those who had the paralytic form of the disease are most at risk for PPS.

It didn't take long for vaccinations to eradicate polio throughout most of the industrialized world. The last case of naturally occurring polio in the Americas was reported in Peru in 1991. Although the disease can still be found in parts of Africa and the Middle East, the World Health Organization hopes that the year 2000 will see the global disappearance of poliomyelitis—and no one will ever again experience the fear, pain, isolation, disability, or death associated with this once incomprehensible and uncontrolled menace.

—Jane Harris Woodside with Alice E. Sink and William E. Wallace

1953

There was danger enough there,
bottom-snagged hooks, bottle jags,
the drop-off that drowned Lee Gregg,
and that summer a belief
disease was easy to catch
as knottyheads where current
slowed and pooled, made a blue hole
beneath the bridge, so grown-ups
forbade that place and children
those long dog days could only
hold in their minds the grapevine's
swing and let go, the cold rush
clamping their chests as they rose
gasping for breath while parents
sweated out August, at night
dreamed of rows of iron lungs
rising from hospital floors
like enemy submarines.

—Ron Rash

Ron Rash won a National Endowment for the Arts Poetry Fellowship in 1994 and the Sherwood Anderson Award in 1996. He has new poems forthcoming in Southern Review, Virginia Quarterly Review, *and* Yale Review. *His first book of poems,* Eureka Mill, *was published by Bench Press in 1998.*

The Grit Behind the Miracle: A Community Builds a Hospital

By Alice E. Sink

Overcoming its own fears, a small North Carolina community comes together during wartime to care for children stricken with polio.

In the summer of 1944, an epidemic of infantile paralysis spread through the nation like a prairie fire. Within 24 hours, a total of 27 cases was reported in North Carolina alone. Most of those afflicted in the state were children from the Catawba River Valley, an area that begins in Lenoir, N.C., and stretches approximately 75 miles southeast to Belmont, near Charlotte, N.C. Isolation wards in Charlotte Memorial Hospital and Gastonia's Orthopedic Hospital filled quickly. Youngsters had no place to go for expert medical attention.

First Steps

On June 21, three physicians met in Hickory, N.C., to make plans for providing necessary medical care to the growing number of afflicted polio victims: H.C. Whims, health officer for both Catawba and Lincoln counties; C.H. Crabtree, North Carolina's representative of the National Foundation for Infantile Paralysis; and A. Gaither Hahn, who was at that time chairman of the Catawba County Chapter of the Foundation. They planned their strategy, deciding to use the Catawba County Fresh Air Camp, a summer experience for underprivileged children, located three miles outside the city limits on Lake Hickory. Whims' first move was to contact Mrs. Earle Townsend at the camp and inform her that she must immediately send all campers home.

Townsend, the camp's dietitian, had sent 57 campers into the nearby woods to pick blackberries for cobbler—a real treat for the children. As Townsend prepared dough in the kitchen, the telephone rang. The caller was Whims, and he

Bett Hudson Eatman

The original stone building that was the Catawba County, N.C., Fresh Air Camp became the nucleus of a new polio hospital when the call came to evacuate the campers in 1944.

Bett Hudson Eatman

Volunteer workers hammered day and night to get Ward Five up and going quickly. Wards were built on either side of the original stone building and were connected to each other.

wasted no time with amenities.

"Mrs. Townsend," he said, "we have an emergency polio situation too large and too severe for existing hospitals to handle. The disease has reached epidemic stages. We need the camp facilities to set up a hospital for the many, many cases of infantile paralysis that seem to be cropping up overnight."

Townsend, who immediately understood the seriousness of the problem, muttered a concerned, "Oh, yes, of course." "And," Whims continued, "I need all your campers ready to vacate within 30 minutes. Will you please see that the children are packed and ready to leave? We've rounded up volunteers in town, and cars will be there soon to take the campers home."

Carpenters and electricians donated their time, energy, and talents, and even artists and dentists hammered nails and toted lumber.

Through the kitchen window, Townsend could see the children returning with their tin cans full of blackberries. They looked so happy, so healthy from their two weeks outside in the fresh air. Quickly she calculated: The dough was rolled, the berries were picked, and the oven was preheated. She could see their excited anticipation. "Can you give us 45 minutes?" Townsend begged. "It's only 15 minutes more. I promised the children a cobbler if they would gather the berries. They've worked so hard, and I want them to have their sweet before they leave."

"Forty-five it is," Whims agreed. "Not a minute more."

"They'll be ready, I promise," Townsend assured him. "And thank you, Dr. Whims."

Whims had one more favor to ask. "Will you stay with us and be the dietitian for the emergency hospital we're going to set up? We really need you, Mrs. Townsend."

Because she had planned to be there anyway for the second camping session, Townsend agreed.

As soon as their telephone conversation was over, Townsend baked the much anticipated blackberry cobbler. Fifty-seven youngsters were enjoying their special treat when the first designated townspeople arrived at the fresh air camp to take them home. Within an hour, the County Welfare Superintendent had all the children delivered safely to their homes.

A Race Against Death

After the last camper had left the site, construction workers gathered in what has been described as "a race against death." That afternoon, Mr. and Mrs. Q.E. Herman, architects from Hickory, designed the new hospital. The existing U-shaped stone building would be the nucleus, with wards built one at a time as needed and connected with boardwalks to the main building or to each other. The moment the Hermans completed their sketches, an urgent call went out for supplies and volunteers. In wartime 1944, wood was scarce; however, truckloads of lumber mysteriously arrived—without bills of lading identifying the sender—at the site. Construction began immediately. Workers installed floodlights so that they could continue through the night.

Carpenters and electricians donated their time, energy, and talents, and even artists and dentists hammered nails and toted lumber. Professional men and women did any task necessary to complete the buildings. Male convicts dug new water mains. Members of the Hickory Fire Department installed hydrants and fire hoses. The telephone company donated a new switchboard. Sewage disposal facilities were expanded. Brush and trash disappeared as units of the State Guard spent hours clearing the grounds. Prominent women from the community scrubbed floors, walls, and beds.

Citizens were afraid; panic ensued. If adults drove past a polio victim's house, they rolled up their car windows.

Those who did not do physical work donated their services in other ways. After an appeal went out for electric washing machines and wringers, Hickory citizens donated such appliances for use during the crisis. Townspeople also gave stoves, hot plates, and toys. From the pulpits of various churches, ministers asked for electric fans. Textile mills sent blankets, sheets, refrigerators, and lamps. People lent their baby cribs.

One broadcast went out from Hickory radio station WHKY: "The hospital now has everything it needs except, of all things, a can opener." It seemed that can

Bett Hudson Eatman

Hubbard hot water tubs, which were used for therapeutic baths, were constructed by the Hickory community volunteers according to specifications provided by a specialist from Johns Hopkins University in Baltimore, Md.

Bett Hudson Eatman

At first, tents were set up to serve as admissions offices. The white truck (r, rear) was the High Point Rotary Club van that hauled iron lungs from location to location.

openers could not be bought in stores in 1944, so the station urged housewives, "If you have more than you need, donate one to the hospital." Even such appeals for small items were answered, so the hospital kitchen staff was soon able to open cans.

Patients Arrive

The first addition to the existing stone building completed, supplies and equipment in place, and doctors and nurses on duty, the Hickory Emergency Infantile Paralysis Hospital opened its doors only 54 hours after the idea had been conceived.

Children admitted to the emergency hospital had trouble breathing; many could not swallow, and most experienced pain in the muscles of their arms and legs. They often complained of headache, nausea, cold, fever, and stiffness of the neck. Mothers and fathers brought some of the children, while others arrived by

As sick children were admitted and treated, more wards went up with additional beds. Volunteers built cribs as soon as the hospital staff filled the ones they had available.

ambulance—with and without parents. According to "Dr. Hahn's Parked Automobile 'Miracle of Hickory' Symbol" which appeared in the August 7, 1958 edition of the *Hickory Daily News*, "There is one thing Dr. Hahn remembers best … It was opening the door of ambulance after ambulance one night and finding the children within them dead. One mother rose from her crouching position over her child and put a finger to her lips. 'S-h-h-h,' she whispered, 'He has been sleeping since we left Charlotte.' The child was dead." Ambulance shortages made it necessary to bring many of the patients to Lake Hickory in hearses supplied by funeral directors.

Hospital staff examined the first patients in the newly constructed admissions tent. However, the crowds soon became so great that others had to receive initial examinations outside. It was not unusual to see mothers sitting on the ground, holding their sick children as they patiently awaited their turn. Workmen still hammered in Ward Two as those early patients were admitted and placed in Ward One. As sick children were admitted and treated, more wards went up with additional beds. Volunteers built cribs as soon as the hospital staff filled the ones they had available.

Since this was an emergency polio hospital, everything was done in a seemingly unsupervised frenzy on an "as needed" basis. Perhaps the community's spontaneous response resulted from the building momentum of World War II, which made people more aware of joining together for a cause in which they believed, as well as from the desperation of the moment.

Staying for the Children

As the epidemic progressed, movie theaters, public swimming pools, and libraries closed along the Catawba River Valley. Children under 13 years of age were not allowed to attend public events, including Sunday school or church services. Citizens were afraid; panic ensued. If adults drove past a polio victim's house, they rolled up their car windows. Travelers on trains passing through "Polio City" closed all the windows as the railcars sped through Hickory.

Yes, people were definitely terrified, but many stepped forward during those critical days. Years after the epidemic, Wake Bridges, a reporter for the *Hickory Daily Record,* said it best: "Had grown-ups been stricken and not children, everybody from the mayor to the street-sweeper likely would have fled town. Nobody felt like running out on innocent children. Hiding the fear that actually had them quaking in their boots, hundreds of volunteers—both rich and poor, those with children of their own and those without—went to the emergency hospital northwest of the city and offered their services."

It was not unusual to see mothers sitting on the ground, holding their sick children as they patiently awaited their turn.

Bridges himself had not always been so brave. At the height of the epidemic, when visitors were not allowed on the premises, Hahn asked Bridges, a photographer for the newspaper, to go to the hospital to make pictures—and a legend was born.

"All right," Bridges said, "but have a big drink of booze waiting for me."

"You'll get the booze," Hahn agreed.

But when Bridges arrived on the site, camera in hand, no booze was waiting.

"I told you," he said to Hahn, "I wasn't going into the hospital without a stiff drink under my belt."

"You'll get your drink when you've

Courtesy of Bett Hudson Eatman

Nurse Bett Hudson (r) watches over a group of children lying outside in the sun, considered at the time the best treatment for polio. Sink's research indicates this was one of the first integrated hospitals in the Southeast.

Bett Hudson Eatman

Harlan Boyles (r), now state treasurer for North Carolina, plays with his brother's handcuffs while a patient at the Hickory Emergency Infantile Paralysis Hospital.

made the pictures," Hahn decreed as he handed Bridges a doctor's gown and mask.

When he finished his ordeal, Bridges again asked for the drink he'd been promised. A doctor handed him a large paper cup with an orange-colored liquid almost to the top. Thinking this was tax-paid liquor, he gulped it down like water.

"Great Scott!" he said, when he finally got his breath. "That was moonshine."

"With a little coloring added," the grinning doctor admitted.

"By that time I didn't have the slightest fear of being felled by polio," he related years later in an April 12, 1980 issue of the *Hickory Daily Record.* "In

Mothers had been giving 10 to 12 hours a day to the fight against infantile paralysis, while fathers exhausted themselves building the hospital.

fact, I soon forgot where I was."

Someone called a taxi, and Wake Bridges was delivered safely back to town.

Settling In

From June 12 to September 27, the Hickory community had been completely mobilized by the polio emergency, and there had been little normalcy. Mothers had been giving 10 to 12 hours a day to the fight against infantile paralysis, while fathers exhausted themselves building the hospital. Once fall arrived, however, it seemed there would be more time to concentrate on other matters.

October brought the recuperating children special visitors, including Baroness Suzanne Silvercruys, a noted sculptor; Maurine Doran Clark, whose husband, General Mark Clark, was commanding the Fifth Army in Italy; and North Carolina Gov. J. Melville Broughton.

Not all visitors were humans, and not all bore gifts. A small mongrel pup, "Polio Pete," waited outside the doors of various wards, hoping to find his master. Workers provided him with a new baby blanket and meat from the kitchen.

Meanwhile, Charlotte Memorial Hospital was building a modern polio facility. On March 5, 1945, a car-and-ambulance caravan transferred the remaining 88 patients from Hickory to Charlotte. Mrs. Earle Townsend, who had been with the children since early June, waved goodbye. She then returned to her teaching career.

During the hospital's nine-month period of operation, doctors, nurses, therapists, and community volunteers treated a total of 454 patients. There were only 12 deaths, an extremely low fatality rate.

A New Era

The Hickory hospital closed, but following World War II, existing buildings became apartments for returning servicemen and their families. Eventually, seven buildings quickly built during the "Miracle of Hickory" were demolished. Today, the original stone camp site has been remodeled as headquarters for the Hickory Recreation Commission. Tennis courts, swing sets, and ball fields fill the space that began as a fresh air camp for underprivileged children and went on to become an emergency polio hospital.

Forty-five years ago, in the spring of 1955, the Salk vaccine, developed by researcher and physician Jonas Salk, was approved for use. The injectable Salk vaccine, together with the oral Sabin vaccine, have eliminated all naturally occurring polio in this hemisphere. Meanwhile, foundations established by Microsoft's Bill Gates and CNN founder Ted Turner have donated a total of $78 million to the World Health Organizations so it can meet its goal of eradicating polio worldwide by the end of the year 2000.

A small mongrel pup, "Polio Pete," waited outside the doors of various wards, hoping to find his master.

Today, there are no woods, no polio epidemic, no hospital—not even echoes of Townsend's call to "hurry up with the blackberries."

It is a new day, a new era. N&T

This article was adapted from material which previously appeared in Alice E. Sink's book, The Grit Behind the Miracle, *and in "The Miracle of Hickory" in the May 1997 issue of* Our State: Down Home in North Carolina.

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The Hickory Emergency Polio Hospital, set up in the summer of 1944, is re-created in the Health and Healing exhibit in the North Carolina Museum of History, Raleigh, N.C. "The Miracle of Hickory" is a part of the largest exhibit yet in the museum building. The Museum is open from 9 a.m. until 5 p.m. Tuesday through Saturday and noon to 5 p.m. Sunday. Admission is free. For information, visit their web site at http://nchistory.dcr.state.nc.us/gen_info.htm, or call (919) 715-0200.

Bett Hudson Eatman

The nurses celebrate the birthday of one of the polio hospital's doctors.

ESSAY

Into the Hills

by Wilma Lewis

A public health nurse finds hope and hardship in the hills of West Virginia

The Moats Family

"I ain't seen nothing for three months now." Sally Moats, the patient who sat before me at my Bobtown, W.Va., storefront clinic, brushed lank blond hair out of her face as she looked up at me. A frown creased her brow as she waited for me to respond.

"You mean you have missed some periods?" I asked. The first time I had heard that statement from a woman, I momentarily thought she was losing her sight. By now, a year of visiting families as a public health nurse in these Appalachian hills had familiarized me with many of the colloquial phrases in common usage.

"Yes, I must be in a family way again." She shook her head sadly. She had brought her six small children to the clinic to update their immunizations, and the youngest, a 3-year-old girl, clung to her as she talked.

I glanced at her family record again and turned back to her. "The last nurse said you were taking the pill. Is that right?"

"Oh, yes," she nodded. "I took it—jes' like she told me to—for a whole year. I figured I was cured."

I bit my lip to keep from laughing. "No, Mrs. Moats," I managed to say, shaking my head slowly. "It doesn't work that way. You have to take them all the time."

"Oh, well," she shrugged, pulling her 3-year-old onto her lap. "It was getting kind a' lonesome without a baby 'round no more."

I told her about the prenatal clinic in Centerville and urged her to go. When we finished, I watched her leave, followed by six small stair-step images of herself, and realized I was shaking my head again. My experiences over the last year had not inured me to the poverty and ignorance I was confronted with in the early 1960s. The contrast with my Midwestern background was astounding to me.

Courtesy of Wilma Lewis

Little Betsy was welcomed into the family the following March. In the meantime, I had seen Sally several times. Mr. Moats was now working in one of the coal mines about 10 miles away. His old pickup truck made it faithfully to and from work each day. Since the job was only temporary, they lived in fear of the day when it would end.

When Betsy was 6 weeks old, I drove out to visit the family again. It was a day as perfect as spring could be in these Appalachian hills. Wisps of clouds floated in the blue sky arching overhead. The redbud blossoms had faded, but splashes of ivory dogwood blossoms nestled among

the new greens of the woods. Mornings such as this made my spirits soar along with the returning songbirds.

Turning onto the narrow road leading to the Moats' home, I passed an abandoned building crumbling in decay. Skeletons of two rusting automobiles perched precariously on the bank beside it.

The house had stood empty for some time before the Moats family moved here two years ago from Tennessee. The house consisted of four rooms and a lean-to shed which was used to store coal for the stove. If the house had ever been painted, there was no trace of it remaining. Some of the windows had been broken and were boarded up until they could afford new glass for them. The former tenant had dumped trash into the well before he moved, and it was no longer usable. Sally carried most of the water they used from the nearby creek. She conscientiously boiled what they used for drinking as she had been instructed by the previous public health nurse.

Walking up the path, I could see Sally's tall, thin figure bent over the washboard. When I knocked on the door, Molly, the small brown dog who had recently adopted the family, came around the corner. She was followed by two waddling puppies. "I see you have added to your family again," I commented when Sally opened the door.

"Yeh, old Molly must have quit taking her pills, too," Sally laughed, wiping her hands on her apron.

Entering the kitchen, I was met by the familiar odors of smoke, kerosene, and the children's wet beds and diapers. I sat down in the chair Sally pulled out for me. "How are things going these days?" I asked.

"Not too good," she said, her face clouding over.

"Are the children all right?" I asked.

"Oh, they's fine," Sally said. "It's the Mister. They've been laying men off at the mine. Things slow down in the spring, and they's got some new machines. He's sure he's gonna be next. He's huntin' a new job all the time. I don't know what we'll do."

I nodded. "I hope he finds something soon." It was a familiar story. Recent mechanization in the mines in the late 1950s was causing a rapid increase in unemployment. Most of the men who were laid off had started working in the mines after dropping out of high school and knew no other trade.

"Me, too," Sally sighed. "If he don't, we might have to move back to Tennessee. I'm so tired of movin'. I'm not sure things are a bit better there, either, but we do have family there." Her shoulders drooped as she talked.

The baby began to whimper in the next room. Sally went to get her. "Soaking wet, as usual," she said as she returned. The smell of urine grew stronger as they came near. "I keep changin' her, but she is gettin' awful sore." She stripped off the soggy diaper. The baby's skin was not only covered with rash, it was pitted with sores. "What kin I do about it?" she looked at me helplessly.

It was strangely quiet. Before I reached the door, I had the feeling that the house was empty.

"How do you wash the diapers?" I asked.

She described her method which seemed perfectly acceptable.

"With all the rain we've been having, it must be hard to keep up with them," I commented.

"Yeh, it's real hard. I dry 'em in the shed when I can't hang 'em outside … an' I only use them two or three times before I wash 'em."

She was pinning on a dry diaper and fortunately didn't notice my shocked expression. "Oh," I said, struggling to maintain a nonjudgmental tone. "You have been drying the wet ones and putting them back on her?"

"Yeh, I don't have too many diapers."

"That may be part of the problem," I explained. "When they dry like that, the urine changes and is lots more irritating. They need to be washed every time they are wet. I'll see if we can get some more diapers by the time I come back next week."

Returning the next week, on yet another beautiful day, with three dozen diapers on the back seat, I left them in the car when I started up the path. It was strangely quiet. Before I reached the door, I had the feeling that the house was empty. There was no answer to my knock. I tried the door, and it swung open easily. Stepping inside, I saw that every piece of furniture was gone.

Outside again, I closed the door and walked around the house. There was no doubt about it: The family had moved. I hoped Jack had found another job. I hoped their next house would have running water—inside. I hoped Sally might even get a washing machine someday.

As I turned to go back to the car, a little bundle of brown fur tumbled out of the weeds and lay crying at my feet. It was one of the puppies. I picked him up and ran my hands over his velvety coat as I carried him to the car. He cuddled up against me and licked my hand as we started toward home. Somehow the day no longer seemed to be so beautiful.

Swingin' Low

No account of public health nursing in these hills would be complete without at least one encounter with a swinging bridge.

My first one was early in the fall the second year I worked in the area. Mrs. Barns, the principal of the Bobtown, W.Va., elementary school, sent me to the James Riley home. The oldest child, Eddie, had entered the first grade that fall and had failed to bring an immunization record.

The Riley family lived back in the woods between Bobtown and Gilroy, W.Va., a small village with a population of about a hundred. The children were bussed from Gilroy to Bobtown for school.

"You can't see the house from the road, but it's not hard to find," Mrs. Barns assured me. "The mailbox has their name on it. You just follow the path through the woods and across the gully.

It's the only house up there." She didn't mention any bridge.

I located the mailbox without difficulty and parked beside the road. Clutching my black nursing bag, I followed the path into the woods. It was a beautiful day with the sun warm on my back. There had not yet been a frost, and the goldenrod, daisies, and blue cornflowers still bloomed along the way. Thistles were launching their downy seeds onto the breezes, and the birds sang joyfully.

I was in no hurry to reach my destination. I stepped over a fallen branch in the path and immediately encountered another lying in the way. Its shiny black bark caught my attention, and I stopped to examine it more closely. As I stood there looking, it started to move, and its entire four-and-one-half foot length slithered silently away.

I had heard about black snakes. Legend has it that they suck milk from the cows and steal eggs from the hen houses and bird nests. They are nonpoisonous and are nothing to be afraid of. My pounding heart did not seem to believe in their harmless nature, though. For several minutes, I watched the spot where the snake had disappeared before I went on my way, carefully examining the footpath ahead of me.

Rounding another bend, I saw the gully yawning before me. Its rocky sides were steep, with a small trickle of water at the bottom. Stretching across it was a bridge.

Two taut steel cables between large trees on either bank supported the 4-foot planks forming the floor of the bridge. Two additional cables were attached at waist height to serve as handrails. At intervals, these handrails were tied to the lower cables to give a modicum of stability to the structure.

The well-worn planks testified that many feet had trod this way ahead of me, and I had no reason to distrust the bridge's safety. Grasping the hand cable, I tentatively stepped onto the planks. Each step I took caused the bridge to quiver under my feet. By the time I reached the middle, it was obvious why these were called "swinging bridges." Even in the light breeze, the bridge gently swayed from side to side. I fixed my gaze on the trees at the opposite bank, fighting the impulse to look down, until I had reached safety.

Beyond the trees at the rim of the gully stretched an open field, dotted with neat corn shocks. Beside the field stood an unpainted house and barn. Round beds of petunias flanked the path to the porch, and a well-kept vegetable garden came into view when I walked up the steps.

Mrs. Riley opened the screen door as I reached the porch. "I've been expectin' you ever since Eddie brought that note home from school," she said. She picked up the little girl who had crawled to the door behind her. "I've looked high and low for that record, and I just can't find it. It musta been lost when we moved here." She held the door open and motioned for me to enter.

"How long have you lived here?" I asked, carefully stepping over the toys strewn on the floor.

"Almost two years now. We moved up from near Bluefield. Jimmy was working in a mine down there, and he hated it. When he hurt his foot in a accident, we

Kenneth Murray

just quit. He said he'd always wanted to live on a farm. This place had been abandoned and was empty when we found it, and we got to rent it real cheap." Her bright blue eyes shone with delight. A cascade of red-gold curls tumbled over her faded blue shirt.

"Had he done any farming before?" I asked.

"Never. His Pa was a miner, too, and got the black lung and died pretty young. That's one reason Jimmy hated it so much. He got a lot of books and talked to people at the Ag school and other farmers, and he's doing pretty well. We've got a cow and some chickens now. Some day, we're gonna buy our own place."

"It looks like you have a good start." I smiled at her enthusiasm. "Did Eddie get his shots down near Bluefield?"

"Yes, at the health department there."

"If you write them, I'm sure they'll send you a copy of the records. Has he had anything more than the baby shots?"

"No. Will he need more?"

"He should have a booster when he starts school. Can you get down to Bobtown to my clinic?"

"Yes, we have a pickup truck. Jimmy went to town with it this morning. It's usually parked out there on the road."

I wrote down the dates for the clinics and handed the paper to her. "You should send for the record right away and bring it with you." I looked down at the baby who was sitting on the gleaming linoleum floor, contentedly sucking her thumb. "What about this one?" I asked.

"I haven't started Susan yet. I should of, I know."

"Well, bring her along. We'd better get her protected before Eddie brings something home from school to her." I rose to leave. "I'll be looking for you at the clinic soon."

The trip back across the bridge seemed much less threatening and the path to the car shorter, though I did tread carefully in the area where the snake had been sunning itself. This visit, full of hope and enthusiasm, was a marked contrast to so many of the visits I had made.

It was spring before I had occasion to go to the Rileys' again. Marsha Riley had followed through with my instructions for her children's immunizations, and when I saw her in the clinic, her reports about home activities were as enthusiastic as they had been the first time I visited.

Eddie attended school regularly in spite of some inclement weather. But late in March, Mrs. Barns reported he had been absent for a full week. There was no telephone in the home, and the nearest neighbor had seen no one leave the house. Mrs. Barns strongly suggested that I should go to the home again.

Donning my boots, I started up the path toward the Riley farm. This trip was a stark contrast to the first one. The day was overcast, and, in place of the leafy canopy of last fall, bare branches stretched above. There was no need to watch for the black snake sunning itself across my path. Recent rains and melting snow had turned the path to mud underfoot.

Rounding another bend, I saw the gully yawning before me. Its rocky sides were steep, with a small trickle of water at the bottom. Stretching across it was a bridge.

When I reached the gully, I was shocked to see the small trickle of water at the bottom had swelled into a roaring torrent barely three feet below the bridge. Adding to the misery of the day, a sharp, cold wind cut through my coat and rocked the bridge from side to side. Recent muddy footprints on the bridge, however, told me that someone had walked across successfully.

Strapping my nursing bag over my shoulder, I grasped a cable with each hand and cautiously stepped onto the bridge. Grateful that I was not prone to motion sickness, I cautioned myself not to look down into the foaming river below and walked hurriedly across to the other side. Weak with relief, I knocked on the door of the house.

"You came across that bridge?" Marsha exclaimed when she flung open the door. "You're braver than I am!" Her husband, Jimmy, was standing behind her.

"I saw fresh tracks, so I figured it was safe," I said. "They were worrying about you down at the school."

"I tried to go down and tell them what the trouble was," Jimmy explained, "but I haven't been able to get the truck started for a week."

"My brother and his family came for a visit about three weeks ago," Marsha added. "After they got home, they wrote back and said one of their boys broke out with the measles the next day. So it wasn't long before Eddie and Susan broke out, too."

"Were they very sick?" I asked.

"Not as bad as I expected," Marsha replied. "I kept them quiet, and they are about over it now. Keepin' them quiet was the worst of it," she laughed.

"Too bad we don't have an immunization for measles yet," I said. "I suppose they will have before too long—now that they have one for polio."

The bedroom door opened slowly, and Eddie peeped around the corner, smiling at me shyly. "Hi, there," I said. "I hear you are about all well. Can I see your spots?" He came over and held out his arms. Pushing up his sleeve, I could see faint traces of the rash. "It looks good to me," I assured him.

Turning to his parents, I added, "You've been fortunate to get by without complications. Undoubtedly, it's due to their basic good health. I hope he'll be ready to come back to school next week."

Picking up my bag, I bid them goodbye and went out into the wind. Even though a cold rain began to fall, I felt happy and optimistic about the future of this family as I approached the bridge, swinging low over the fearsome, foaming flood. N&T

Wilma Lewis is a graduate of the University of Wisconsin School of Nursing. She worked in public health nursing in Appalachia in the late 1950s and early 1960s. Later, after graduating from the School of Public Health at the University of North Carolina, she taught community health at Kansas University and the University of Wisconsin. She is now retired and living in Madison, Wis. She has published a historical novel, Will, *as well as short stories and poems.*

When It Comes to Health

Everyone's an Expert

The Madison County Health Coalition

by Jane Harris Woodside

Appalachians show how neighbors can help neighbors tackle public health problems.

Back in 1989, a small group of Madison County, N.C., residents and agency representatives received a W.K. Kellogg Foundation grant to work on improving their community's health care. "One of the things Kellogg funded, and it wasn't the lion's share of the money, went toward implementing a community-oriented primary care process of health planning and organizing," remembers Thomas Plaut, a sociologist on Mars Hill College's faculty who worked on the project. "In retrospect, though, this is what has changed all of our lives."

The Kellogg Foundation, based in Battle Creek, Mich., is a nonprofit organization founded in 1930 by W.K. Kellogg, the cereal industry pioneer. The foundation numbers community-based health services among its current grant priorities.

Developed by two physicians, Sidney and Emily Kark, while working with the Zulu in South Africa in the 1940s, community-oriented primary care (COPC) is a four-stage process designed to identify and then address an area's health issues. As Plaut describes the process, "You define the geographic area and everybody in it, you find out how people define health and illness and its causes, and on the basis of the people's definition—not the professionals' but the people's definitions—you undertake actions that make sense to local people." The final step is to evaluate the projects to gauge their effectiveness and to figure out how to do it all better the next time.

Madison Community Health Consortium

Judy Futch facilitates a listening session at a Madison County, N.C., resident's home to find out what the community's health concerns are.

Listening

The health planning process in Madison County began with a basic assumption: Everybody has expertise when it comes to health care. "It's not just the health professionals who know about the problems in our com-

munity and what to do about them," Plaut asserts. "It's the parents, the teachers, the senior citizens, the ministers and county extension agents, the volunteer firemen who go out there and see what people are dealing with every day. The key message has always been that if you involve the people in the county from the start, you can't help but be successful."

When the project team faced the first task, that of identifying the community, they enlisted the aid of the county's postmasters. Mail carriers turned in their lists of how Madison County people defined community. There were 72 neighborhoods in a county with a population of 17,000 and covering 450 square miles. Faced with such a daunting patchwork of subcommunities, the project staff decided to talk to as many different groups as possible.

Between August and December of 1989, Plaut—along with physician and epidemiologist Suzanne Landis and June Trevor, who had previously worked with the developmentally disabled in the county—began the process of community-based research that would define the project over the coming years. Assisted by a college student, they conducted 40 "community listening sessions," small group interviews in which a two-person team posed about half a dozen open-ended questions about health issues, existing barriers to health care, and possible solutions and then recorded the group's responses. All told, 416 county citizens participated in these sessions. "Later, we received some teasing for conducting so many listening sessions," says Plaut.

Madison Community Health Consortium

A program to administer dental sealants to elementary school children to prevent cavities was one of the first projects implemented by the health alliance with the help of public health dental care providers.

"But we thought we had to talk to as many people as were out there in some sort of organized group, and that's what we did."

It was critical that project staff members travel to the people rather than expecting people to come to them. "You go to people's home turf," explains Plaut. "You don't bring them to a place where they're not comfortable. You go where they interact at least weekly. So we talked to churches, to volunteer fire departments, scouting group leaders, and to sheriff's deputies. We talked to doctors and nurses, and we talked to teachers."

What was interesting, he continues, was that although people might initially be reluctant to participate, they quickly warmed to the task. "We were often asked at the end of the meeting, 'Can you come back? Can we do this again?' They had the chance to talk about things they'd all been thinking about but had never really had the chance to share with each other."

Next came the hard part: boiling all the data down to a manageable size and then presenting it to the Kellogg project's community advisory board (CAB). The CAB started out as a cross section of public and private service agencies and community groups and became even more of a cross section as time went on. Anyone could become a member; the meetings were completely open-door affairs. As a result, the coalition grew from 25 to 40 people during the project's first two years. By the spring of 1992, the CAB moved from being the grant project's advisory board and became a true ongoing community health alliance, the Madison Community Health Consortium (MCHC).

Grassroots Public Health

Between February and March of 1990, the project staff presented the CAB with its interview findings—along with statistics on illness and causes of death as well as demographic and economic data culled from federal and state sources. What emerged after a comparison of the interview material and the statistical data were a number of health problems. For example, it became apparent that the county was experiencing higher than expected rates of dental decay among children; of pneumonia and influenza among the elderly; lack of compliance with recommended infant immunizations; and of deaths from the complications of diabetes. Where to start? "You'll find that there's a collective passion about something, and that's where you begin," says Plaut.

During that first year of the grant (1989-90), the group organized several projects. Public health dental care providers went into the schools and administered dental sealants to help prevent cavities. Project staff and the CAB

"You define the geographic area and everybody in it, you find out how people define health and illness and its causes, and on the basis of the people's definition—not the professionals' but the people's definitions—you undertake actions that make sense to local people."
—Thomas Plaut

"If you involve the people in the county from the start, you can't help but be successful."
—Thomas Plaut

launched a flu-pneumonia immunization campaign aimed at senior citizens. They also enlisted the aid of a Parent Teacher Association at a remote school district to recruit and train lay women to disseminate information about immunizations and child safety resources to parents of newborns.

Another key to the success of these programs is that health care providers and educators take their services to the people. "With our diabetes program," says Plaut, "instead of making folks go to Asheville, we not only offered it in the county, but we went to several localities. The program was done in Mars Hill, in Hot Springs, in Marshall."

This strategy addresses the barrier to health care that transportation often poses in rural areas. But more than that, it overcomes a cultural barrier. According to local residents, "When you tell health care practitioners in Asheville that you're from Madison County, they sometimes treat you quite badly. People in Asheville, I think, often want to be sure you know that although they might be living in the mountains, they're not those 'mountain folk.' Local people know that. They say, 'I don't want to go there and be treated like dirt.'"

Most importantly, coalition projects address issues the people themselves articulate. "We've got 911 in Madison County now because everyone said there was a terrible need," points out Plaut.

Madison Community Health Consortium

To accommodate senior citizens' concerns, a senior health fair is held each October. The fairs have been attended by about 500 people each year since they began. Participants in the fairs can get flu and pneumonia immunizations and screenings by physicians and dental practitioners.

Assisted by a college student, they conducted 40 "community listening sessions," small group interviews in which a two-person team posed about half a dozen open-ended questions about health issues, existing barriers to health care, and possible solutions and then recorded the group's responses.

There were 13 separate emergency numbers, each one with its own jurisdiction. Critical time was wasted as people tried to track down the right ambulance service to respond to a crisis.

Consortium members successfully raised more than half a million dollars in federal grants that allowed the county to install a state-of-the-art 911 system. Writing these successful grants and implementing the system was possible because of the existence of the coalition and the skills its members had acquired.

Not only is there a communitywide organization ready to act, there is also an unprecedented degree of trust and cooperation. Says Plaut, "When we decided to take on the 911 project, we had volunteer fire departments help with the mapping and renaming of the county's roads. Each road name had to be distinct enough so that, for example, an ambulance called to go to Crooked Street wouldn't go to Crooked Creek Drive. One of my neighbors, a fellow who runs a lawn service, took it upon himself to talk to everybody on our ridge about changing the road name. He solicited proposals for new names, sent them out, and people voted. And there are stories like that all over the county. Volunteers like him saved the county more than $40,000. It was a huge effort."

The grassroots origins of the health partnerships and their surprising results are apparent. For example, in neighboring Mitchell County, which in 1998 set up a coalition similar to Madison's, health care providers were puzzling over how to get the word out about "Flu Shot Saturday," a day when immunizations are available at a number of sites throughout the county. Newspaper distribution was limited, and radio reception was often poor. A volunteer fireman stepped forward with an ingenious solution: Broadcast the news about the shots over the fire department's countywide emergency scanning radios. Lots of people listen to scanners while driving down the road, and some even had them in their homes. It worked like a charm. "By using this system, which costs exactly zero, they now reach a whole lot of people they weren't reaching before," notes Plaut. Public health announcements continue to be broadcast weekly.

"You see their eyes light up: 'Wow, look what we can do.'"
—June Trevor

Action Building on Action

Creating this sort of community coalition isn't an easy process, and it can't be rushed. Observes Trevor, "Generally it takes a year to a year-and-a-half for the group to gel, to figure out its identity." Initially, each individual and agency comes to the table with an agenda, wary of others encroaching on his or her turf.

Plaut remembers one physician who was offended by resident comments made during the needs assessment in the coalition's early days. "You're stirring the community up against us," the doctor scolded. Carolyn Haynie, Madison County Health Department director, remembers that 10 years ago, county agencies only contacted each other when there was a problem, "and then you'd get on the defensive as to whose problem it is."

But once these fledgling coalitions successfully realize a project or two, things begin to change. "Actions build upon action," says Plaut. For example, the flu-pneumonia immunization program has evolved into an annual senior health fair. That fair gives Madison County's elderly a chance to take advantage of a range of offerings, from flu shots to physician screenings to information about living wills. And they have the chance to reconnect with old friends and acquaintances, itself no small contribution to their overall health. "It just keeps growing," says Plaut with satisfaction.

Successful projects have a less tangible but absolutely crucial impact on the coalition. Once members get a chance to view the fruits of their collective labor, the coalition turns an important corner. "When

Once members get a chance to view the fruits of their collective labor, the coalition turns an important corner.

It became apparent that the county was experiencing higher than expected rates of dental decay among children; of pneumonia and influenza among the elderly; lack of compliance with recommended infant immunizations; and of deaths from the complications of diabetes. Where to start?

they begin to see that pulling off something like this isn't so hard, when you get more people to take up pieces of the work and share it, that's when you start to see that common agenda rising up above all these individual agendas," says Trevor. "You see their eyes light up: 'Wow, look what we can do.' And that's the real transformation. It's fun to watch."

Physicians come to understand that the coalition is actually making their lives a lot easier. Agencies begin to have a very different type of conversation with each other. "Now you realize that it's not my problem and it's not the department of social services' problem," says Haynie. "It's *our* problem. And we're working together to find the answer." Trevor agrees, "We can come together and be proactive. We can prevent the problems from even occurring."

Having a neutral facilitator to help give birth to the coalition is essential. The Kellogg grant funded a coordinator, a position Trevor filled until 1993. With the end of Kellogg's funding in 1993, the Hot Springs Health Program, a primary health care provider with four medical centers in the county, has helped fill the gap by allocating 10 percent of health educator Nancy Wilde's time to coordinating the MCHC. Other agencies in other counties also provide staff and other resources for MCHC projects.

Trevor and Plaut now work with the Asheville, N.C.-based Mountain Area Health Education Center (MAHEC), whose mission is to improve the quality, geographic distribution, and retention of health care professionals in the region by serving as a bridge between the state's educational institutions and the health care delivery system. Trevor coordinates MAHEC's Community Health Resource Services, providing technical assistance to other health partnerships forming elsewhere in Western North Carolina. Currently there are 11 partnerships serving 13 counties.

It's certainly time-consuming, even when other county task forces have discovered that they have the resources to conduct only 10 to 20 group interviews, rather than Madison's original 40. Not all counties accomplish their original needs assessment by conducting extensive interviews. Some use surveys and questionnaires; others have pieced together the results of recent smaller-scale assessments. In fact, not all counties follow the COPC model. "But whatever model they use, it's usually the same thing," says Plaut. "It's just a common sense, internally driven approach of 'let's look at the community we're trying to serve.'"

Finding funding is an ongoing hurdle. Trevor says, "There is a dependence on soft money, and few grantors are willing to give money for a process." While many county coalitions have developed formidable grant-writing skills, still, as Trevor says, many run on "community support, sheer volunteerism, and agency willingness to allow some of their staff to help out."

Working Together

Last January, the MCHC met at a local technical college shortly after a paralyzing snowstorm had closed many roads in the county. Still, there were between 20 and 30 members in attendance, taking stock of what they'd accomplished the year before and making plans for 2000. The public health department let coalition members know that they had started a lending library of sorts for cancer patients in need of wigs or prosthetics. The child health task force announced that it had recalibrated a goal upwards to 90 percent now that the county has increased its childhood immunization rate from 66 to 80 percent over the past year. And the group initiated a discussion about how to help low-income people take advantage of not very well publicized pharmaceutical programs offering free medications.

"Actions build upon action."
—Thomas Plaut

In the midst of it all, one older participant proudly exclaimed, "This group works together. Nobody here ever says *I* did it. I think it's just wonderful how this group works together."

Now in its 10th year of operation, the Madison Community Health Consortium is alive and seems entirely healthy in the mountains and valleys of Western North Carolina. N&T

Jane Harris Woodside edits Now & Then.

Creating Community Partnerships

by Bruce Behringer

ETSU works with Northeast Tennessee communities to revolutionize how we educate health care professionals.

The W.K. Kellogg Foundation believes that the medical education of primary care providers needs to look very different in the 21st century. It has backed up that conviction with the millions of dollars it has invested in encouraging new models for health professionals' education in Appalachia as well as in other areas of the U.S.

Health care education needs to be taken out of large hospital complexes and placed back into the very communities where health care professionals are needed most. If providers are going to work effectively in these communities, they need to learn to listen to and respect what their citizens have to say. If doctors, nurses, and allied and public health workers such as environmental health professionals, audiologists, and speech therapists are going to work together as a team, they should be trained together. The key to it all is creating a series of two-way partnerships: among the members of various disciplines within universities and then between those universities and their surrounding communities.

> Health care education needs to be taken out of large hospital complexes and placed back into the very communities where health care professionals are needed most.

Based in Battle Creek, Mich., the Kellogg Foundation is a nonprofit organization founded in 1930 by W.K. Kellogg, the cereal industry pioneer. In June 1991, through its establishment of the Community Partnerships for Health Professions Education Initiative (CPHPE), the Kellogg Foundation committed $47.5 million to the idea that communities have a legitimate role in helping to teach the next generation of health care providers.

Together with community leaders in two medically underserved rural counties in Northeast Tennessee, Johnson and Hawkins, East Tennessee State University's (ETSU) health sciences division received $6 million and over the next seven years reshaped its education of medical and undergraduate nursing and public and allied health students. West Virginia University in Morgantown, W.Va., was the other Appalachian recipient.

Partnerships

Five years later, in 1996, ETSU was one of the three original CPHPE participants selected to receive an additional $1.8 million each for the second phase of the program, the Graduate Medical and Nursing Education Initiative (GMNE). Kellogg's GMNE program—which included a total of six community-univer-

> Forming partnerships often does not come naturally to those in higher education.

sity consortiums—applied ideas, values, and innovative teaching methods gleaned from the community-based CPHPE curriculum to the education of nurse practitioners; graduate allied and public health students; and medical residents, who are physicians receiving special post-medical school training.

Forming partnerships often does not come naturally to those in higher education. Institutions are organized into separate colleges and discrete departments that cultivate specialized knowledge and sometimes compete with each other for scarce resources. When they do venture out into the community, it is often to create short-term relationships that meet very specific, limited course objectives.

In 1991, ETSU established the Office of Rural and Community Health to create and nurture the university-community partnerships mandated by the Kellogg grant. As ETSU's Rural and Community Health Office began putting this innovative program together, it had to start from scratch. There were no similar programs anywhere in the country, no blueprints to follow.

Larry Smith, ETSU University Relations

Community representatives and East Tennessee State University faculty and students from three different disciplines meet as part of the Johnson County Nutrition Coalition. The group plans school-based teaching and community education campaigns to improve eating habits to reduce heart disease and Type 2 diabetes. Pictured are (from l to r) Debbie Green, public health student; Evelyn Knight, public health faculty; Beth Lowe, nutrition faculty; Paula Stewart, nutrition educator from the Johnson County Health Department; and Jim Florence, public health faculty.

As ETSU's Rural and Community Health Office began putting this innovative program together, it had to start from scratch. There were no similar programs anywhere in the country, no blueprints to follow.

The office operates on a different set of assumptions than those usually guiding conventional health professions education. It firmly believes that while providing an excellent education for ETSU's students, the program can also supply much needed services to underserved communities.

Kellogg believes that trust and respect are the keys to making the program work. Therefore, the majority of members on ETSU's governing structure for the program are community representatives: school teachers, a hospital administrator, local business people, and elected officials. They serve alongside the deans of the colleges of medicine, nursing, and public and allied health. In addition, Hawkins and Johnson counties both organized local advisory boards to give counsel and direction to the university about how to create educational experiences that would bring a community-based curriculum to life.

Mock Epidemics

What has resulted from the CPHPE program at ETSU is a three-year rural primary care track, currently chosen by up to a quarter of the university's medical, nursing, and public health students. Several features make this track differ markedly from prevailing health education courses of study. First, all of the students learn together for part of their training, regardless of their discipline. Also the curriculum is based on experiential learning principles, where students learn by doing in both rural health providers' offices and out in the community rather than solely by listening to lectures.

Finally, community-identified needs and available resources dictate what students learn. Organized around nine courses, the rural primary care track curriculum includes classes in communication, rural and community health, and health assessment techniques. The curriculum complements the classroom and laboratory-based courses which rural track students also take on campus along with the rest of their classmates in medicine, nursing, or public health.

For example, the track instructs students about the realities of community public health and epidemiology through participation in a mock epidemic. Community members volunteer to act as patients stricken with food poisoning, for

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instance. Students walk into their community classroom and are given 75 or so names of "patients" whom they need to contact and interview during the day. As an interdisciplinary team, they must identify the cause of the illness and the source of the offending toxin.

Students identify and address very real problems as well. In Rogersville, Tenn., a town of 4,000 located in Hawkins County about an hour's drive from ETSU, another interdisciplinary team screened 600 elementary school students and found that 40 percent could be classified as overweight. They're now at work with local educators and health professionals designing prevention interventions to address this long-term risk factor for coronary disease in a county that has been plagued for years by a high rate of deaths due to heart disease. Over in Johnson County, students are working with the home for the aged, trying to improve the quality of care being delivered. They are learning about how the elderly can be cared for in rural counties, helping with clients, and talking with families about care options.

Office of Rural and Community Health, ETSU

Lisa Duerbeck, an ETSU nursing student, explains the food pyramid to first graders at a health fair conducted at Rogersville Elementary School in Hawkins County.

Students walk into their community classroom and are given 75 or so names of "patients" whom they need to contact and interview during the day. As an interdisciplinary team, they must identify the cause of the illness and the source of the offending toxin.

These same principles also guide ETSU's Graduate Health Professions Education program (GHPE). The graduate programs integrate interdisciplinary experiences for students and family medicine residents into their already packed curriculums, building on the region's community health issues and resources. One example is a recent graduate seminar on end-of-life care; it drew upon the expertise of nurses, physicians, social workers, public health professionals, and preachers from both local communities and the university. Over 130 graduate students investigated issues in small interdisciplinary groups.

In 1996, the rural community of Del Rio in Cocke County, located between Johnson City and Knoxville, was confronted with an environmental crisis. The state water quality division closed a local stream to recreation after a hepatitis outbreak. Environmental and public health students and faculty worked with community groups to conduct a massive survey to determine where people got their water and identify potential sources of water pollution. They simultaneously worked to gain an understanding of how area residents used health services. The community invited the students in and guided them through the experience of learning about how to respond to an environmental hazard in a real community.

The Model Works

Now in its ninth year, the model continues to work. Operating without Kellogg funding, these experience-based, community-based programs keep on drawing students. The rural primary care track curriculum attracts an average of 36 medicine, nursing, and public health students who are divided into two cohorts—one based in Rogersville in Hawkins County, the other in Johnson County's Mountain City. The GMNE program activities have averaged 168 graduate students during its first three years, again largely volunteers for community-based experiences and multidisciplinary seminars.

Most importantly, over an eight-year period, 17 percent of health science students in the rural primary care track have come from Johnson and Hawkins counties. ETSU students are clearly serving as role models for the young people of those communities.

There is significant ETSU faculty involvement in these programs. In addition to a number of full-time faculty who teach, practice, and conduct research in Rogersville and Mountain City, there are over 30 university and community faculty members from the three health science colleges who teach in these two localities. An additional 38 graduate health science faculty are involved in the GMNE program.

This community-based, experiential philosophy of education is beginning to spill over into mainstream courses as well.

This community-based, experiential philosophy of education is beginning to spill over into mainstream courses as well. For example, the health sciences division is planning that all future health care practitioners—rural track and non-rural track students alike—will sharpen interpersonal, interviewing, and diagnos-

tic skills by taking a divisionwide communication course. The course will include mock clinical visits with lay people who role-play patients as well as an assignment which requires students to interview community members about different health issues.

In 1999, the Kellogg Foundation gave ETSU yet another grant, this time $1.25 million, as part of the Expanding Community Partnerships program. This program encourages ETSU to take what it has learned from redesigning health sciences education and apply those lessons to the rest of the university. It challenges the colleges of arts and sciences, applied science and technology, business, and education to establish partnerships in Hancock and Unicoi counties as well as Johnson and Hawkins.

For example, last year, ETSU English and theater students and faculty collaborated with the Butler Museum Committee to produce a play, *River Rising: TVA and the Town of Old Butler.* It told the story of the old Johnson County town of Butler that had been flooded in the 1940s by the Tennessee Valley Authority's construction of a dam. The play was performed in Johnson County and will continue to be staged as part of its Old Butler Days annual festival.

Larry Smith, ETSU University Relations

Buddy Clayton, a Mountain City family physician, examines a role-playing patient as part of a health assessment class in which an interdisciplinary team of medical and nursing students gains hands-on experience from a rural health professional. The students are (from the l): nursing student Daniel Guinn, medical student Ai-Khue Nguyen, nursing student Gaila White, and medical students Gary Plant and Candie Templeton.

Lasting Benefits

In addition to having a far-ranging impact on the university's curriculum, the health education programs have provided much needed care to these medically underserved communities. Between 1998 and 1999 alone, family medicine residents and nurse practitioner students contributed 13,000 hours of clinical care in community-based sites throughout Northeast Tennessee and Southwest Virginia. In Johnson and Hawkins counties, physicians and nurse practitioners have provided primary and preventive care services valued at $800,000 annually. Statistical studies have demonstrated decreases in mortality rates and increases in the use of preventive services.

Perhaps most importantly, students have learned that, as one medical student said, you need to "view patients as individuals and see them outside the context of the short episode in which you provide care. I like it very much when I see my patients on the street because this provides me with a bigger picture of how I fit in and the significance of the care I am giving. It has made me realize that effective medicine is really all about continuity."

Providing health services to underserved areas does not stop with graduation. Of the first seven rural track physicians who have totally completed their training, six are currently practicing in towns of less than 5,000; 50 percent of nursing graduates took positions in rural or nonhospital settings. Often these health care providers are taking jobs in the communities that they first got to know through the rural primary care track. Since they already have a good feel for the community, and the community knows them, it should increase the odds that these health care providers will stay in these underserved areas.

Creating community partnerships with the citizens of underserved areas has relied upon the trust that has been created between individuals. It requires the university's endorsement of the notion that community-based learning is valuable and that communities can contribute to the educational process. These partnerships grow experience by experience, project by project and are nurtured with the continuous communication, cooperation, and collaboration that define the university's relationship with rural communities. N&T

> Most importantly, over an eight-year period, 17 percent of the health science students in the primary care rural track have come from Johnson and Hawkins counties. ETSU students are clearly serving as role models for the young people of those communities.

Deborah Brown, *an evaluator for the GHPE;* ***Susan Grover,*** *interdisciplinary curriculum director for the rural primary care track; and* ***Jo Lobertini,*** *Expanding Community Partnerships program assistant director, all collaborated with Bruce Behringer on this article.*

Bruce Behringer is assistant vice president in the health sciences division at East Tennessee State University, Johnson City, Tenn., and executive director of the Office of Rural and Community Health and Community Partnerships. The office administers the Kellogg Foundation grants awarded for the Community Partnership Programs.

Rattlesnakes

by Romulus Linney

The Shooks and Ab Mullins carried Malcolm into the yard. Sassy Plankman yelled for her husband, Griswold. They laid Sassy and Griswold's son down on a quilt on the porch.

"Keep him on his stomach," said Spencer Shook. "On his back, the poison moves faster."

Griswold came running, as did his daughter, Rachel, behind him. He'd had her on his shoulders, plowing. They all gathered around Malcolm. The boy had to fight for his breath, it was that bad. He had been playing with the Shook boys on the Shook farm, in plain sight of Spencer Shook and Ab Mullins, who'd happened by to talk guns.

"Where?" said Griswold.

"In his shoulder," said Ab Mullins. "And anothern, in his jaw, jist over his throat. There, see?"

"Twice?"

"At onct!"

"What were they?"

"I want to say copperhead, but diamondbacks is what they was. Tell by the marks."

"Around here," said Spencer Shook to Sassy, "they can be the size of your arm."

"Rattlesnakes?" said Sassy.

Griswold got out his knife. "Son, I got to cut on you. Hold still." Malcolm nodded. Griswold found the bites. He cut an X on each place. He bent his head and sucked those wounds, first one then the other. Nobody else did anything.

Spencer Shook watched him do it for a minute. "Mr. Plankman," he said. Griswold paid him no mind. "Griswold," said Ab Mullins. The two looked at each other. "Let him alone," said Spencer Shook.

"It was the sun," said Ab Mullins to Sassy. "Serpents come out."

"Maybe breeding," said Spencer Shook.

And in deed and in truth, two diamondback rattlesnakes came off a waist-high ledge at the boy. Both bit him the same split second. One hung off him long enough for Ab Mullins, on the run the minute he saw it happen, to knock one serpent down and blow off its head with his twelve gauge. "I kilt one fore it could coil," he said. "Othern was gone."

Griswold tried to turn Malcolm over, on his back. "Don't do it," said Spencer Shook. "Son, turn over," said Griswold. "I can't," said Malcolm. "Hep me here," said Griswold to the men standing around watching him. So Ab Mullins and Spencer Shook helped Griswold get Malcolm over on his back, so Griswold could get his knife and his mouth to Malcolm's jaw. Then they stood there, watching what they knew was useless, with worse to come.

Two diamondback rattlesnakes came off a waist-high ledge at the boy. Both bit him the same split second.

"Can't hardly breathe now," Ab Mullins said to Spencer Shook. "Griswold," said Spencer Shook. "Cutting and sucking for the diamondback won't do. Copperheads, adders even, but not diamondbacks." "Goddamnit," said Griswold, spitting blood and poison, "don't tell me that!"

"Momma?" said Malcolm.

"Malcolm?" said Sassy. Malcolm didn't say anything else.

"I'm telling you, this won't do no good now," said Spencer Shook. "The venom's running inside him. He's black in places, see?" Ab Mullins said, "It's a fact."

"Hold his head," said Griswold to Sassy.

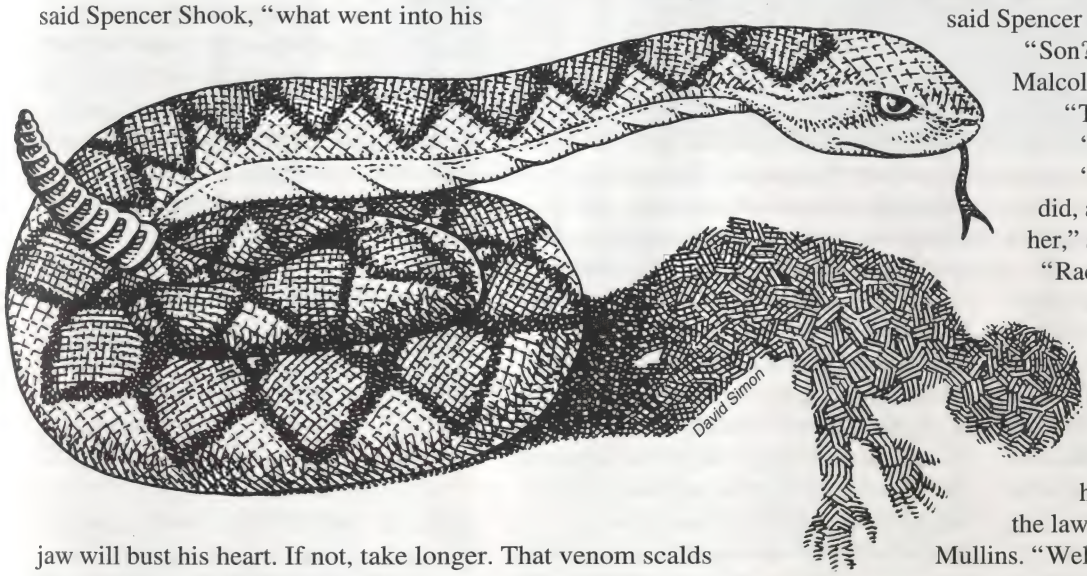
"You'll jest disfigure the boy," said Ab Mullins. "Make the torment worse," said Spencer Shook.

Sassy understood them. Malcolm's groans turned into whimpers. "Griswold, you hear what they're saying?"

"Just hold onto him!"

Spencer Shook and Ab Mullins, too, held onto Malcolm. Griswold cut into him again, deeply, above and below Malcolm's neck and then again into his shoulder. Malcolm whimpered, bit his lip til blood came out there, too. Griswold spit, sucked again and again, then cut again. More groans, more sucking. It was like something a man would see in a whorehouse. Sassy said, "Griswold, no more!"

"It's in him like his own juice," said Spencer Shook. "Commencing to swell up," said Ab Mullins. "If he's lucky," said Spencer Shook, "what went into his jaw will bust his heart. If not, take longer. That venom scalds the veins apart. Fills his body all loose with blood." "That's what's black," said Ab Mullins. "In one day, a grown man can be five times the size he was when he was bit," said Spencer Shook. "Can't say what will happen to a boy." Ab Mullins said, "It's the painfullest way any soul can leave this earth."



Ab Mullins and Spencer Shook helped Griswold get Malcolm over on his back, so Griswold could get his knife and his mouth to Malcolm's jaw.

Griswold wanted to kill them both, talking like they were buying horses. Sassy saw they were right.

"Stop, Griswold," she said. Griswold sat back on his heels.

"My brother," said Spencer Shook. "The diamondback hit him was the biggest ever seen hereabouts. It was thick as a log. I seen it hanging from a pole, tall as a man." "Nobody can abide that kind of poison, let alone this boy," said Ab Mullins. "We wish it wasn't so, but it is." "Twenty-six hour the longest I seen," said Spencer Shook.

Griswold cut into him again, deeply, above and below Malcolm's neck and then again into his shoulder. Malcolm whimpered, bit his lip 'til blood came out there, too.

"Ain't there cures?" said Sassy.

"No, ma'am," said Spencer Shook. "That's just talk."

"I got to do this?" said Griswold.

"No other soul," said Ab Mullins.

"I'll need to witness some kind of a yes from him," said Spencer Shook. "It's the law."

"Son?" said Griswold. "Understand?" Malcolm nodded.

"That'll do," said Spencer Shook.

"What's this?" said Sassy.

"Kiss him," said Griswold. Sassy did, about to cry. "Somebody hold her," said Griswold. "No," said Sassy. "Rachel, kiss your brother." Rachel did. Griswold held out his hand for the twelve gauge Ab Mullins had under his arm. Ab Mullins stepped back and shook his head.

"Can't be no bullet or shot in him," said Spencer Shook. "It's the law." "Make it a crime," said Ab Mullins. "Well, how?" said Griswold. "Do what you was doing, with your knife," said Spencer Shook. "It's the way my brother was set free of it." "We can say it ain't no crime then," said Ab Mullins. "Best do it now," said Spencer Shook. "'At venom is splitting open his veins," said Ab Mullins.

"Yes, Griswold," said Sassy.

Griswold hit Malcolm hard on the head with the butt of the knife. Malcolm's eyes closed. Griswold cut his throat.

"Push on him," said Spencer Shook.

Griswold pushed down on Malcolm's chest. A gush of bright blood poured out of his throat. He was dead soon. N&T

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Romulus Linney is the author of three novels and many plays produced throughout the United States and abroad. He was recently awarded The Award of Merit Medal for Drama from The American Academy of Arts and Letters.

Telemedicine

A Marriage of Medicine & Technology

by Bill Dockery

Physicians can bring their expertise to remote rural areas without ever leaving home.

The patient is in the examining room when the dermatologist walks in. They make eye contact and exchange greetings, and the doctor begins to ask questions about the skin condition that is the reason for the exam. With the help of a nurse, the doctor carefully inspects the troublesome skin problem. He asks a couple of more routine questions, then diagnoses the condition and prescribes a remedy. After a little more casual conversation, the doctor leaves the room, and the nurse helps the patient get ready to go.

When the doctor looks at the image of the patient's face on the screen, the patient sees the doctor making virtual direct eye contact.

That scenario sounds like a routine played out thousands of times a day at clinics and medical centers across Appalachia, but this particular exam was out of the ordinary.

The patient and the nurse are at Woods Memorial Hospital in Etowah, on the edge of the Cherokee National Forest in Southeast Tennessee. The doctor is more than 50 miles to the north, sitting before a bank of television cameras and monitors at the University of Tennessee (UT) Medical Center in Knoxville, Tenn. Doctor, nurse, and patient have just participated in a fast-growing phenomenon that is providing specialized health care to people isolated from urban medical centers. A marriage of medicine with rapidly maturing telephone and video technologies, interactive telemedicine is a trend that has the potential to change the way rural residents of Appalachia receive medical and mental health care.

Medicine, Not Technology

" 'You need a specialist.' That's the statement that sets it in motion," says Barbara Kincaid, the registered nurse who coordinates the activities of the UT Telemedicine Network. When one of the network's referring physicians in LaFollette or Huntsville or one of the other five remote locations in Tennessee decides a consultation is needed, Kincaid takes the call and sets up a time for doctor and patient to meet virtually over the telenetwork.

"The concept here is of two exam rooms connected together. They function as one room," says Sam Burgiss, the director of the network. "We want the provider and the patient to feel as if they're in the same room. After all, we don't practice telemedicine. We practice medicine."

Burgiss, who has a doctorate in electrical engineering and a background in

"Almost every specialty has something that can be done via telemedicine."

— Sam Burgiss

marketing medical instruments, explains the setup of cameras and monitors. The room in Knoxville has a camera that provides the patient a view of the whole room and another camera that is set at eye level in front of the monitor that shows the doctor the patient's face. When the doctor looks at the image of the patient's face on the screen, the patient sees the doctor making virtual direct eye contact.

In the remote room, the patient can see the doctor and on another screen can see the view that the doctor is examining. A nurse at the remote site operates a handheld video camera to show the physician the area of the patient's body causing the health problem. A third camera in each room is used to transmit documents and X-rays. Every step of the process is care-

fully thought through, Kincaid says, from the doctor's entry into the room to the placement of the cameras and what the doctor and patient see on the monitors.

Use of the network has grown from 24 visits in 1995 to 1,882 in 1999. Many of the referrals come to the dermatologists associated with the medical center, although UT anesthesiologists are increasingly using the system for pre-anesthesia screenings of patients coming to Knoxville for surgery.

The network makes use of three levels of telecommunications technology: a T-1 line, equivalent to 24 regular phone lines, that provides extremely high-resolution images; ISDN lines which allow for high-speed data transmission; and regular phone lines. Coupled with highly sensitive electronic stethoscopes and other electronic medical tools, the telemedicine technology offers a surprisingly wide range of diagnostic abilities. "Almost every specialty has something that can be done via telemedicine," Burgiss says.

The UT Graduate School of Medicine funds the network through public and private grants, including monies from the U.S. Department of Health and Human Services' Office for the Advancement of Telehealth and the Department of Commerce's Telecommunications and Information Infrastructure Assistance Program. The UT Medical Center pays the salaries of the three staffers. Patients referred to the network pay the consulting doctor just as if they were making an office visit. Insurance typically covers a virtual visit to the doctor just as it would a same-room examination.

"So far, we've not had a third-party provider fail to pay," Kincaid says. "The single biggest barrier to telemedicine is Medicare." Kincaid says Medicare rules require that a physician be present in both the remote location and the hub site, which defeats any cost-saving for the patient.

Virtual Eyes and Hands

Bruce Ingram works in the UT network's satellite exam room at Woods Memorial Hospital in Etowah. A 1992 graduate of St. Joseph Hospital School of Nursing in Memphis, Tenn., Ingram works directly with patients referred to the telemedicine program. His job is to reassure first-time patients and then to wield the handheld digital video camera that allows a Knoxville physician to conduct the examination. "The digital camera just absolutely works wonders," he says. "It provides super-clear pictures. When there are questions the camera image can't answer, then I am the doctor's extra set of eyes and hands." In the two years he has worked with the program, Ingram says the examining physicians have come to trust his observations about the few physical issues that can't be determined from the televised image. The doctors who refer to the UT telemedicine program do a good job of preparing the patients for an examination via TV, Ingram says. "I tell them where to sit and show them the cameras and the monitors."

UT Telemedicine Network

Increasingly, sophisticated technologies allow a telemedical network to enhance rural medical care with easy access to specialists. Here a physiatrist, a specialist in physical therapy, is able to examine a patient's prosthesis long-distance.

Most of the patients Ingram sees are a bit camera-shy at first, but a few get over it alarmingly fast.

Most of the patients Ingram sees are a bit camera-shy at first, but a few get over it alarmingly fast. "We try to be discreet," he says. "If someone has a rash in the groin area, we'll ask them to put on a hospital gown and try to preserve their modesty. But some just open the robe right up. The doctor will say, 'OK, we got that picture, that's good,' and we quickly switch to another camera."

The UT telemedicine program pays attention not only to modesty issues but also to confidentiality and privacy. The video signals are digitized and encoded and transmitted on dedicated lines, Burgiss says.

The UT Telemedicine Program has served children as young as five or six. They adapt to telemedicine techniques fairly quickly, Ingram says. "Typically, they're pretty tense, a little uptight, just like in a regular doctor's office," he says. "I explain the camera and take a picture of myself to try to get them to loosen up."

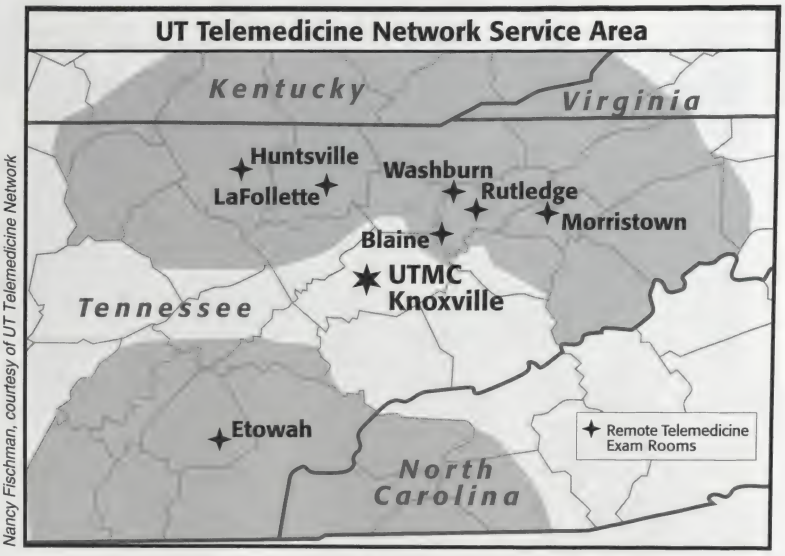
Ingram confirms that the patients he has worked with have expressed a high level of satisfaction with the virtual examination process. "Everyone just really likes it because it saves them that drive to Knoxville or Chattanooga. Most of the responses have been highly favorable. The few who weren't satisfied were usually concerned that their medical condition hadn't been resolved by whatever treatment the doctor prescribed."

Convincing doctors that the technology is valuable is more difficult. "One of the hardest sells is the physician. We have to convince them that they can really make a diagnosis," Burgiss says. "Some of the most successful programs are in the Midwest, where the doctor may be 200 miles away. The hospitals are owned by corporations that insist on the telemedical process."

David Shupp, a dermatologist associated with UT Medical Center, is a recent convert to the technology. "The system is really convenient for the patients," Shupp says. "I'm still in the learning curve, but the camera has very high resolution and gives a good picture of problems. I can't touch or feel or do scrapings, but I can make an accurate diagnosis and convey information to the patient." He echoes

Ingram's words: "You have to rely on the nurses to help you orient. They're your eyes and hands, as well."

UT is putting the technology to other uses besides long-distance exams. In 1999, the program provided more than 400 patient visits via Home Touch, a video technology that uses low-tech modems and normal telephone lines to monitor homebound clients who have chronic health problems. A similar program, Baby Touch, lets mothers observe their newborns who are confined to UT Medical Center's intensive care nursery. In some instances, the network's handheld cameras have gone on UT's LIFESTAR helicopter ambulance and broadcast images of injured accident victims back to the hospital's emergency rooms.



Nancy Fischman, courtesy of UT Telemedicine Network

The UT Telemedicine Network's service area includes seven remote sites serving rural parts of Tennessee, Kentucky, North Carolina, and Virginia. Without this high-tech network, some patients would drive more than two hours to see a specialist.

On the Virtual Couch

The technology that has proven useful for medical purposes in Tennessee is being applied successfully for psychiatric purposes in Southwest Virginia. The Appal-Link Network in Cedar Bluff, Va., supplies outpatient services to the clients of the Southwest Virginia Mental Health Institute in Marion. Cedar Bluff lies about 25 miles southwest of the institute. "Because our hospital is located in a mountainous rural area, people have to travel over twisty mountain roads. It takes a long time," says Clifford Hall, the psychiatrist who is the institute's medical director. "Often it's not convenient for families to come down." Hall says the technology makes follow-up care of patients after their discharge from the institute much easier and more effective. First of all, the network makes it much easier for the institute's staff to involve family and treatment teams from the patient's community in meetings on the patient's condition. "And then we are almost always able to arrange for patients to be followed by the doctor who treated them in the hospital," Hall says. "All in all, the continuity of care made possible by the network has cut down on our readmission rates."

"People are so accustomed to the cathode ray tube in their lives that it's almost like the technology disappears."
— Clifford Hall

The program screens for patients who must have face-to-face contact. Surprisingly, Hall says, clients experiencing paranoid delusional problems who might be expected to regard the video cameras as threatening have not been overly concerned about the technology. "We were attentive to that potential," Hall says, "but very few people turn it down or are unable to use it for that reason."

Appal-Link uses intermediate communications technology to serve 10 sites in an area bound by Blacksburg, Bristol, and Bluefield, Va. Its ISDN lines have the carrying capacity of three normal phone lines. Transmission costs prevent the network from using the broader bandwidth available in the T-1 technology. "Our problem is we have four different telephone companies," says Henry Smith, director of Cumberland Community Services Board, which created the network in 1995 and continues to oversee it.

Smith says the network has been especially helpful in both civil and voluntary commitment hearings. Family members and witnesses from the community can participate easily without having to drive to Marion.

Like the UT program, Appal-Link reports a high level of patient satisfaction. "The general results have been glowing," Hall says. "People are so accustomed to the cathode ray tube in their lives that it's almost like the technology disappears. You really feel like you're sitting with the person you are dealing with."

The Top 10

Both Appal-Link and the UT Telemedicine Network rank in the top 10 of the roughly 200 telemedicine programs in the nation, according to the December 1999 issue of *Telehealth,* the magazine of the fledgling industry. The Virginia program is praised for "improving the quality of care for hundreds of severely ill patients" in its service area. The publication cites the UT program for "the very personal approach to patient needs" that the three-person staff takes. A top-10 ranking in the growing field is no small honor, especially for two small programs.

Kincaid, a UT alumna and a health care veteran, is excited to be part of the new program. "I see offering telemedicine to rural people as a wonderful service. We're giving consumers something they need, making it easier for them to get the advanced health care they need."

As competition in the health care industry intensifies and telecommunications technologies improve and become more affordable, the growth of telemedicine as a source of health care for rural Appalachians looks assured. N&T

East Tennessee native Bill Dockery is a science and technology writer for the University of Tennessee, Knoxville. His last article for Now & Then *was a profile of African American architect DeWitt Dykes in the spring 1999 issue.*

Mobilizing Moms in the War Against Tobacco

by Michael G. Meyer

Appalachian mothers might well hold the key to preventing and eliminating tobacco use.

In a conversation last summer among a group of women in a rural tobacco-growing county in Eastern Kentucky, one woman volunteered, "My mom and dad both smoked, and they had six children—and none of us smokes. And Mom and Dad smoked the whole time we were home."

The woman's comment intrigued me and my colleagues, public health analyst Mary Toborg and sociologist Mary Mande. It intrigued us since we knew that having a parent who smokes is a strong predictor of smoking in offspring and because we knew that research shows that people in Appalachia are more likely to smoke than are Americans who live in the rest of the country. It intrigued us still more because we have been seeking insight into ways to prevent tobacco use in the Appalachian mountain region.

When a nonsmoker credits a smoker with preventing tobacco use, something worthy of investigation is going on.

Mande asked the woman from Eastern Kentucky why neither she nor any of her siblings smoked. Without hesitation, the woman replied, "Momma always said, 'Why would you wanna put somethin' in your mouth and set fire to it?'" Although the woman's mother smoked, all the same she persuaded her six children to do as she said and not as she did. When a nonsmoker credits a smoker with preventing tobacco use, something worthy of investigation is going on.

Dr. Mom

Not too long back, a national brand of cough medicine ran a series of commercials that spotlighted Dr. Mom's tender mercies. In the advertisements, the pharmaceutical company that made the cough syrup featured mothers who treated the colds of

Gerald Gentry

Brenda Kuczuzyski-Hamilton steals a moment with her children (l to r), Daniel, Alesha, and Kerri. Women in the Appalachian Mountain region play a pivotal role in ensuring the health of their families.

their famous offspring. In one ad, for instance, the mother of Shaquille O'Neal offers her physically and athletically prepossessing son, an NBA basketball star, a quaff of the becalming elixir.

The Dr. Mom commercials did not leap out of a void; their pitch relied on a basic fact. Most people intuitively know—but never consciously consider—that just about always in almost every household, there is one person who takes responsibility for the health of the family. That person is usually Mom. Dr. Mom's the one who shows the children how to wash their hands after they go to the bathroom, brings them soup when they're sick in bed, and pressures Dad to go to the doctor when he's not feeling well.

Although this phenomenon is probably universal throughout all cultures, it may prove particularly important among families who live in Appalachia. The physical and emotional closeness of nuclear and extended families in the mountains almost surely makes it a wonderful conduit to spread information. Ohio University's Sharon Denham, for example, observed that members of the extended families in Appalachian Ohio she studied in 1996 shared with one another the health information they acquired from doctors and learned in the media. The question then becomes: "What is the best way to gain access to the family in a way most likely to influence the family's health?" The answer, I believe, is women because of the unique function they enjoy in the life of the family.

If a mother is armed with the right tools, she may be able to affect her family's health-related behaviors. But before that can happen, it's necessary to understand what concerns mothers so that we can craft tools they will actually use.

Focusing On Tobacco Use

I, along with Toborg and Mande, work for Toborg Associates, Inc., a Washington, D.C.-based research firm. Since women in Appalachia play a key role in keeping their families well, we have been talking to women up and down the mountains about their perspectives on preventive medicine.

Gerald Gentry

Shawn Ramsey fishes in North Carolina's brilliant summer sun. Women in the region believe that to be effective, conversations about tobacco need to start when children are young and continue as they grow older.

Though our interest has included the general role of women in maintaining their family's health, our more immediate concern has been how Appalachian women can prevent tobacco use among their young, discourage secondhand smoke in the home, and help their husbands to quit tobacco use. This work is funded by the National Cancer Institute as part of its ongoing efforts to reduce tobacco use and its harm to public health.

Although the "Dr. Mom" phenomenon is probably universal throughout all cultures, it may prove particularly important among families who live in Appalachia.

Since the summer of 1997, we've talked to 128 women in focus groups in 14 Appalachian counties in 10 states. Eight of these focus groups were in tobacco-growing counties, where we talked to 76 women. We anticipate talking to about 70 more women in nine other focus groups by the end of the summer of 2000.

The focus group is a research method for understanding how people think about specific issues. In a focus group, generally six to 12 persons with similar characteristics join together in a discussion with a researcher, who directs the conversation around a specific topic.

We have had focus groups on a variety of different tobacco-related topics. In one set, we explored participants' reactions to various tobacco prevention materials, showing them ones we had collected from around Appalachia and asking them to explain to us what they liked or did not like about the content. In another set of focus groups, we explored women's perspectives on their own ability to prevent their children's use of tobacco. We also have conducted focus groups on the prevention of secondhand smoke and the cessation of tobacco use.

This project has cut a wide swath through the region—from Pennsylvania, Maryland, Ohio, West Virginia, Virginia, and Kentucky to Tennessee, North Carolina, Georgia, and Alabama. Naturally, there have been some differences in the attitudes among the women whom we have studied, attributable perhaps to biases in individuals and variations within the region. Still, a coherent set of observations about health and tobacco education in Appalachia has begun to emerge.

What Appalachian Women Think

• **If women in Appalachia perceive that a change in their behavior will enhance or protect the health of their young, they generally are prepared to act on a health-related message.** Consistently—whether it be women who quit smoking because of pregnancy or families who forbid smoking in the house because of a sickly child—there is willingness to make great personal sacrifices for the health of children within the family.

Notably characteristic of comments from all over the region, a woman in a western county of West Virginia mentioned that she had quit smoking when she became pregnant with her daughter. Since that time, she hasn't permitted smok-

ing in her home. She advised her grandmother, who is a smoker, that "as long as she's around the baby, she can't smoke in the house." Her assertiveness has succeeded: The woman reported that her grandmother has complied. On the other hand, her grandmother no longer comes by very often.

• **Women in Appalachia do not want their children to smoke or use smokeless tobacco.** In our focus groups, no women wanted their children to use tobacco, regardless of whether or not they lived in a tobacco-growing area or used tobacco themselves. Women with economic ties to tobacco perceived the crop as merely an agricultural enterprise. As a woman from a tobacco-growing family in Western North Carolina allowed, "It puts food on the table." But no woman who grows the crop has ever expressed the wish in any of our focus groups that her children use tobacco.

Gerald Gentry

Scott and Michele Luther hold on tight to their baby girl, Courtney. Many families in the region now forbid smoking in the presence of their infants and young children.

Women who did not use tobacco seemed to have greater confidence in their ability to affect their children's behavior than did women who smoked. A nonsmoking woman in Northeastern Alabama observed about her efforts to influence her young son: "I always try to talk to my 12-year-old about peer pressure and let him know that he is his own person." Even though she occasionally has her doubts, she figures that she must be getting through to him because she has noticed that "a lot of things he does, he does the things *he* wants to do. He knows he's not supposed to be like everybody else."

Women who use tobacco feel hypocritical about advising their children not to use. Even so, these women usually regretted their tobacco use and wished they had never started. Both women who used tobacco and those who did not expressed deep concern about the influence of outsiders, such as indifferent adults who might buy or give tobacco to their children and the "wrong crowd" of kids who might pressure their children to pick up the habit.

It's necessary to understand what concerns mothers so that we can craft tools they will actually use.

The women in our focus groups suggested the need to talk to young people about tobacco at an early age and to continue that conversation frequently as children get older. As one woman in Southeastern Ohio advised, "You don't just tell them once. You've got to tell them every day." Another woman in the group agreed, saying, "Yeah. You think they learn everything in that one conversation?" Women in our groups intuitively understood that a one-shot approach to health education with their children was not realistic.

• **There is a wide understanding and acceptance that secondhand smoke is harmful to children. Smokers in Appalachia are prepared not to smoke around infants and children.** There were lengthy discussions in focus groups about the serious health consequences that affect children as the result of secondhand smoke. Many participants reported incidences of ear and respiratory infections that they believed resulted from secondhand smoke, and they were knowledgeable about the need to avoid smoking around children. The husband of one woman in a southern West Virginia county even quit smoking for six months when his child was born; he was never able to quit either before or after that six-month period. Women often reported their families had banned smoking in the home to protect their young ones.

Many of the women and their husbands were not smokers, but their parents were. A testimonial to the power of family in Appalachia: Some grandparents went so far as to quit smoking so they could visit their grandchildren. Almost all participants who discussed the subject indicated that friends and family had no problem going outside to smoke if they were asked.

This willingness, however, may not extend any further if children are not in the picture, and it may be once again a testament to just how powerful the desire is in Appalachia to protect the young. One woman in Western North Carolina reported she observed smoking in hospital stairwells near an intensive care unit where patients were recovering from heart attacks. Based on reports from our focus groups, despite official bans on smoking in restaurants and stores, smokers in many places in Appalachia nevertheless feel no compunction about lighting up, and it is rare that management personnel will make the smoker put out the cigarette.

• **Participants in the focus group did not like messages that seek to make people or institutions look stupid.** One theme that has repeated itself over and over again is that messages which insult an institution are doomed to fail. Tobacco prevention messages that attack the tobacco industry such as one poster does, "Let the tobacco industry die, not you," are unacceptable in tobacco-growing communities not only because many people perceive themselves as part of the industry, but also because they consider such gratuitous comments to be impolite.

But the same holds true in areas where there is no dependence on tobacco money. Over and over again across the region, if a message made an institution, a parent, or another individual look obtuse, participants swiftly rejected it. People in Appalachia are too courteous to accept an insulting message.

• **Prevention messages must be concrete and make sense within personal experience.** The women expressed a desire for practical messages that are relevant to their circumstances. For instance to point out, as one health education brochure does, that cigarettes have arsenic in them and that arsenic is a rat poison didn't ring true to participants. As one of them retorted, "I don't see people dying like rats from smoking cigarettes."

Many participants reported incidences of ear and respiratory infections that resulted from secondhand smoke, and they were knowledgeable about the need to avoid smoking around children.

But participants do respond well to messages that recall a memory or create an image. For example, women in our focus groups reacted very positively to a test message that asked them to remember when they were children and their parents smoked in the car. It ended by asking why they'd think that their own children would like it any better now.

The Next Steps

All of the initial research we did—on how folks in the mountains respond to existing materials—and all of the current research in which we are engaged—on how women in the region think about preventing tobacco use among youth, secondhand smoke, and tobacco cessation—are leading to the development of new health materials. From spring 2000 to the following autumn, we will be giving the materials we are developing to different groups of women and coming back later to see what impression they made. We think the women in our focus groups have taught us a lot about how to develop materials they can use. And—who knows—if we have understood what they've told us, perhaps they've made it possible to develop useful materials in areas of health prevention, from other substance abuse to cancer to HIV/AIDS. Time will tell. N&T

Michael G. Meyer is project director at Toborg Associates, Inc. in Washington, D.C., for a research project funded by the National Cancer Institute to investigate culturally appropriate tobacco health education in the Appalachian region.

Alzheimer's

My mother's ten again—
a pot of beans on the woodstove
clothes drying in the back yard
parents intact in their separate beds.

She knows the smell of beans cooking on the woodstove
but has forgotten us, my sisters and me,
remembers only her parents asleep in their beds,
has forgotten ever being fifteen.

She's forgotten giving birth to my sisters and me,
forgotten my dad, the war years,
or, earlier, leaving school at fifteen
to work in the company store.

Forgotten being married, living through the war years,
feeding younger sisters and brothers,
forgotten those hours in the store,
her father's lungs filling with coal dust.

She knows she has sisters and brothers,
clothes drying in the back yard,
knows the taste and feel of coal dust.
My mother is ten again.

—Connie Jordan Green

Ted Cooley

Connie Jordan Green is the author of two award-winning novels for young people, The War at Home *and* Emmy. *Her poetry has appeared in* Now & Then, Confrontation, Cumberland Poetry Review, Iowa Woman, *and* Sow's Ear. *Green writes a weekly newspaper column and teaches writing at the University of Tennessee in Knoxville. Her mother was 84 when she died June 14, 1999.*

Afterlives

Hands.

I finger my father's hand, its stumpy thumb truncated during the Depression when he worked for Coca-Cola, driving a delivery truck through Asheville's poorest neighborhood, downshifting to first on the hilly narrow streets so people could steal drinks from the back. That place is gone now, leveled during urban renewal: I can see its ghost out the hospital window, shining like a scar.

I finger his square thumb, its permanent nail no bigger than a paring, a stained sliver of moon in the winter sky. My father stirs in his pharmaceutical sleep.

I move to leave, but he grabs my hand like a newborn: a voracious grip, punctuated by squeezes. Is it just muscle and pulse, the heart's involuntary morse, I feel? Or is it (as I want to believe) intentional, the code he taught me as a kid, the love we could speak to each other anywhere without saying anything, three quick squeezes ...

Phantoms.

I was born upstairs in this hospital and — after complications — was assigned to an oxygen tent in the hall, my anxious parents peering in, breathing for their only son.

A bracelet of bright plastic about the bone.

My mother died here three years ago this month. My father is dying here now. I will not die here, in godforsaken February, haunted by the phantom pain of family.

Dream-Poem.

I dream my mother visits my father and me
in the house where we always lived. She's dead
but nobody mentions it. She seems very unhappy

and won't stay still, she keeps pacing the rooms.
Soon she leaves, walking across the dusky yard
without looking back. As she slowly drives off,

dad turns and says, "I just don't understand this."

Signs.

Cardiac Intensive Care. With the heart, how could it be otherwise?

Waiting Room. I fidget in the relentlessly cheerful waiting room, waiting again for the appointed hours. All around me, people are rehearsing their pep talks, their unmonitored hearts pounding against something thicker than blood.

Immediate Family Only. When someone is dying, all family is immediate.

LIBERTY.

How I craved this silver dollar,
the last thing dad laid on his chester-drawers
before bed, the first thing pocketed.

517 combat days, son.

He's handled, palmed, fingered it so long
its circumference is warped, its serration bald,

its features worried away.

I flip his fate in the sterile air.
Tails: the captive eagle looks like a vulture,
its wings an ironic V.

Heads: the goddess is exhausted,
her weak eye weary
of scrutinizing the E in E PLURIBUS UNUM,

her bad ear barely able to hear
(like a heartbeat)
1921.

But even after half a century
of friction, the habitual secret rub for good luck,
one word still crowns her fading head:

LIBERTY.

Holy, Holy, Holy.

Visiting Hours, the only canonical hours we keep here.

My father's body flickers, his parched lips twist with a collage of language, a faint glossolalia. I swab them with a foam sucker, a cheery cherry flower dipped in water.

Maybe the monitor is senile, maybe it too has suffered a stroke, maybe it is an outcast prophet chanting the same phrase over and over again …

Pete and Repeat.

My dad would say, "If Pete and Repeat were sitting on a fence, and Pete fell off, who was left?"

"Repeat," I'd answer.

"All right. If Pete and Repeat were sitting on a fence, and Pete fell off, who was left?"

"Repeat," I'd say again.

"All right. If Pete and Repeat were sitting on a fence, and Pete fell off, who was left?"

Suckered into his exasperating game, but doomed by honesty, good manners, and an angry queasy fear, I had to repeat, "Repeat."

"All right. If Pete and Repeat were sitting on a fence, and Pete fell off, who was left?"

And so we'd go, until I covered my ears and ran from the room.

Dream-Poem.

My mother is waiting on the wide shady porch
of an old house in the country. I can't see her
but I can sense her, the rhythm of her rocker.

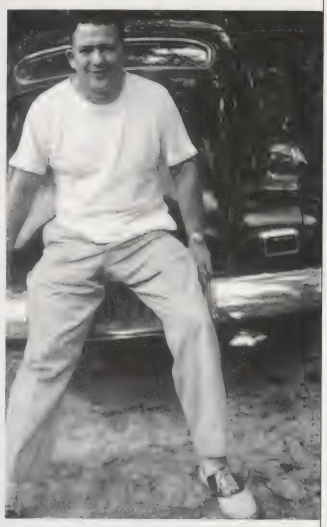
I've been driven there in a yellow convertible
with the top down. It's early fall. I'm nervous
because I know she'll smell the beer on my breath.

But the dream ends before I get to the steps.

Missions.

I watch my father labor to breathe, strapped into his oxygen mask like a pilot setting off on another top-secret mission, Destination: Unknown, pushing the envelope.

So Much Paper.



My father's body has been talking a blue streak. Nobody listens for three quarters of a century, but now they've got him wired like an undercover agent or an astronaut, saving every fascinating whisper from the interior.

So his body is dictating nonstop, an autobiography of astonishing detail, a colossal manuscript-in-progress down at the nurses' station. Wolfe's prodigious ghost drifts in from Riverside Cemetery: He is jealous, he never had this many secretaries, not even on his best night could he fill so much paper with so much ink!

I'd like to read the book of my father's body, but I'm not allowed: It's written in a code I don't understand. But I do know that its last line will be a line, the plain geometry of *a* to *b,* the shortest distance between two points but infinite in its density.

I.V., T.V.

They tether my father to I.V.s, lash his bruised arms to the mast, anchor him to intricate machines so that gravity can't swallow him through the valley of the shadow of his bed, so that he won't float to heaven through the pay T.V.'s always-open window.

Gravity Is a Jealous God.

The day before my father dies, two attendants transfer him to a stretcher simply by untucking the sheet and lifting him still on it, in a makeshift sling. This is not very difficult to do because, by this time, my father is not very heavy. Gravity has been evaporating him during his month in the hospital. His arms and legs are shocking to touch, all bones and skin; his face is shrunken, his mouth a foul fallen cave.

When the men lower my father, his hospital gown rides up. I happen to be looking where his genitals are, or were: there is little left anymore but a white blur, as if they've been airbrushed away.

Gravity is no respecter of persons. I guess if he had lived longer, it would have kept melting my father away until it reached his heart and its freshly-patched aorta, the last mass of ice to thaw.

Beaucatcher.

I look out the hospital window at Beaucatcher Mountain. Generations of Asheville lovers used to court there, beaus and their catchers spooning, sparking, necking as the town spread its winking lap of lights below. Then an interstate's open cut bisected the mountain, its passionate slopes blasted to so many stories of air.

I wish my father could see his amputated life made whole again: that missing thumbtip; the leveled hilltop neighborhood; those ghostly turnouts on Beaucatcher where he used to park with my mother; my mother …

Executor.

The sheer business of dying
displaces grief, makes it seem a luxury
for the peripheral or lazy,
for those not dealing

with the funeral home and its upper room
of coffins, with proper flowers,
with the free-lance preacher,
with neighbors and their heartfelt food,

with the sealed sentence of will and estate,
with the doleful realtor
measuring the house like an undertaker,
with tortuous claims and benefit…

I do, I am, I have, I will.
Grief suppressed may never come at all.

Afterimages.

Movies depend on persistence of vision, a *trompe l'oeil* whereby the retina retains each frame's image just long enough that it overlaps with the next one, creating the illusion of continuity, kinesis, motion pictures. So do dreams, splicing together footage from the day's rushes, from memory, from the uncensored id.

And so do the dead, their afterimages lingering among the living for a while, in a series of vivid cameo appearances.

Dream-Poem.

My mother's words glow through closed curtains,
the sad aftertaste of a dream that left me this:

I will lament the most lamentable use of language
that ever was. I will lament the world.

His Snores.

A few weeks after my father dies, I dream I am driving our old Rambler station wagon around the neighborhood — the green Ambassador, with straight shift on the column, the one he taught me to drive in the school parking lot on Sunday afternoons. It is early evening, early spring, mild, quiet.

Dad is falling asleep in the backseat. He tries to stay awake, but, as usual, fails: The narcolepsy plays him like a lure, his head bobbing backwards, tempting the great black fish we never see. Soon his mouth sags open and, with a startling gulp, he starts to snore.

In the dream, I drive around and think:

His snores a dark tide
flooding the world.

I stop in front of a friend's house; he waves and comes across the yard. "Hi," he says, "how's it going? How's your dad?" As if on cue, dad fractures the dusk with a snore so loud it sounds like the

Rambler has backfired. "Oh!" says my friend, stepping back in surprise. *"Oh,"* I whisper loudly, nodding toward my dad. "I know he *seems* to be in the backseat, but actually he's dead." And then I say to the evergreens: "If such a thing can be a blessing, then this was."

And my dad snores a hearty *Amen,* and sucks in another lungful of dim air, holding it and considering it and savoring it on his palate, a connoisseur of oxygen, a virtuoso of respiration, the Houdini of sleep, and I sit clutching the cracked wheel, waiting for him to come back as he always had before.

Ritual.

I haul my father's junk mail
to the burning barrel
one last time,

that miracle of carbon and rust
and mostly air, balanced
on cinderblocks in the sideyard.

I deal the letters
evenly, set three matches
to the pyre of sweepstakes and insurance,

watch the fire catch,
the wavy heat ascending in shadow
like fumes at a pump,

the huge flakes of ash
floating
overhead and downwind through the trees.

I wait for a while,
until the pocked body of the barrel
is cool again, then take from it

what I need:
carbon for grief, rust for rage,
and gallons of airy ash for penitence.

Afterlives.

Gradually, the afterimages of the dead start to fade, become less frequent: empty screen, empty page, empty seine of sleep…

But my father still gets urgent fat envelopes from *Reader's Digest,* guaranteed offers from Universal Life, invitations from a Christian Tour group, to which I finally write: "My father is dead. Do you have any discount tours of the afterlife?"

His Body.

I dream I am pacing my father's sold house one last time, scouting for one more memento. I come to his chest of drawers, that high altar of secrets, emptied long ago.

The top drawer is still empty, except for some roly-polies. Likewise the second drawer, which has even more. The third drawer sticks, and once I get it open it's completely lined with bugs. I have to jerk the fourth drawer out: it's half-full of grubs. And once I manage to crack the bottom drawer, it overflows with bugs and maggots and worms, all pouring out onto the bedroom floor.

I have to get a broom! I think. *The new owners—*
But when I turn, there's my father in the doorway, smiling, silent. And slowly I realize that what had seemed a freckle, or mole, or liver spot, or bruise, or scab, is in fact an insect, one of a calm swarm of bugs, so many that I can never brush them all from his body.

Gloves.

I pull on my father's old work gloves
against the stunted month of his dying,
his sloughed cells still stuck in the fleece,
my hands warming as his were chilling
that last hospital day, so stiff

they felt like a pair of worn-out gloves
he'd leave in my grip when he slipped away,
the ghost of his surrendered gestures,
a trick handshake, a second skin

my body would take a lifetime to fill
until that cold day when the gloves finally fit.

February.

I've come to hate the very sound of this month, this runt of the calendar's litter: feeble, febrile February. *Rue* is at its heart.

And I do rue its coming, every year, my parents vanishing again like vapor off a thawing pond: holy smoke.

It's a cul-de-sac, the dead end of the year: dead presidents, dead saints, dead mother and father: dead year.

Dream-Poem.

My mother's pallbearers stumble toward her grave
with a book the exact same volume as her coffin.
As it passes by, I seem to see my name on it.

I want to say to the dark: *This is just a dream.*

Michael McFee teaches creative writing and literature at the University of North Carolina at Chapel Hill. McFee has written five books of poems and edited an anthology of contemporary North Carolina poetry, The Language They Speak is Things to Eat. *His work has appeared in* Now & Then, Poetry, Hudson Review, Tri-Quarterly Review, Virginia Quarterly Review, *and elsewhere.*

The photos accompanying this poem are all courtesy of Michael McFee. Page 33: Top: McFee's father (on the right) worked for Coca-Cola in Asheville, N.C.; bottom: Michael McFee (at home at three weeks of age) spent time in the hospital in an oxygen tent after birth. Page 34: Top: The 1921 Liberty silver dollar which belonged to McFee's father shows the effects of handling over the years; bottom: five-year-old McFee sits with his mother and father. Page 35: McFee's parents took snapshots of each other in the late 1940s. Page 36: "The house where we always lived" in Arden, N.C., south of Asheville. Page 37: The reverse side of the Liberty dollar shows as much wear as the front. Page 38: McFee's mother's grave in Green Hills Cemetery in Asheville in a photo taken by his father.

This is the Life

by Geoff Fuller

"A life of charm and dissonance," the man says, raising his shot glass in exaggerated salute. He's three empty stools down the bar, and there's no one on the dozen stools to his right, clear to Gabbie's broad front window. The blind is drawn, and summer light pours in through the slats. I can't really see him, just a silhouette in work boots and a flannel shirt with a backdrop of people passing on the bright sidewalk outside. My right foot tingles as if asleep, as it has all day, and I watch him tilt back his head and drain the amber fluid, which sparkles briefly at the edge of his shadow.

Out the corner of my eye, I can see the bartender shift from ignoring the man's words to attending to the empty glass. He thinks the man has had too much to drink, but he pours anyway, his face studied disinterest, the purest conspiracy between pusher and addict. He knows this guy. I don't know what tells me that, the strained angle of the bartender's head, maybe, or the fact that he says nothing friendly, just, "Two dollars," despite the fact that there are only three of us in the bar. Trapped in the hours between the lunch crowd and the steady additions of happy hour, we are lost in this cavern, high ceilings and great expanses above the bar and all the long way to the back bathrooms. This is when bars resemble churches most. Taped music plays, but it is Suzanne Vega, and it is soft.

"What's that?" I say to the guy, lowering my newspaper crossword to the bar. The guy turns, startled, as if I hadn't been there before. His broad face has thick eyebrows. He was only a presence when I came in an hour ago and passed his hulked shoulders, noting only that he held his glass with two hands, both elbows on the bar.

"What?" he says.

"Something about charm," I say and motion to the bartender for another. Eight one-dollar bills sit there, beside my nearly empty beer mug. I edge two ones toward him with the backs of my fingers. Seventy-five cents is a plenty big tip.

"Oh, yeah," the man says, smiling crookedly, wagging his finger vaguely in my direction. He leans toward me on his stool, dangerously toward me, it seems, like he's going to pitch over, and raises his eyebrows with his revelation. "Ours is a life of charm and dissonance. Yours and mine. You should remember that, buddy."

I shouldn't have spoken to this guy. I see where this is heading: A drunk at the bar, recently divorced, now regretting it.

I nod somberly. "It is the best of times, and it is the worst of times. I am the alpha, and I am the omega." I raise my mug and flex my foot under the bar. "Got it. I've never felt charmed myself."

The guy shakes his head, confused. "I was just thinking about Cindy. My wife for five years. Until about a month ago. I couldn't do anything about it. She just … let herself go."

I shouldn't have spoken to this guy; I see where this is heading: A drunk at the bar, recently divorced, now regretting it, but by God, there was nothing he could do because the woman let herself get fat. I've had this conversation before, and this time, I'm too tired to pretend interest.

"You don't understand. Cindy was everything to me." He perches his head forward and narrows his eyes as if trying to see me clearly. "The problem is, I thought she was what I

deserved in this life, but now I know she was what I *hoped for.* Now she's gone. You see?"

I don't know what the hell he's talking about, but I nod. "She was the charm, and the divorce was dissonance?"

"No, no. Cindy was my charm. Definitely." A small, wistful smile curls his lips. "I became what she imagined me to be." He shakes his head as if to clear it and continues speaking, slowly, with overcareful enunciation: "Okay, look. We're white guys, right?"

Oh no. Not a racist rant. We get that around here, lots of *It seems like they get everything* closely followed or preceded by, *I'm not prejudiced, but you know…* I usually don't say anything.

"You and me—" His head swivels, and he sees the bartender, carefully standing a dozen feet back, rubbing a glass with his cloth and eyeing us warily.

"—and him, we're all white guys. Most people aren't."

No kidding.

"I mean," he says, "half the white people are women, and Christ, they've got their own troubles. Everyone else is something else than white. We're a minority, but we're the ones that got all the stuff, the ones everyone bows to. You and me, buddy."

He raises his glass in toast; I raise mine. We drink. This isn't quite the approach I'd expected. He grimaces after his sip, and I exhale satisfaction after mine.

"Look," he says, "you're not saying much, but I've got to tell you I'm rich."

"Get out." I have to say something because that's what one does in response to drunken nonsequitors, especially when they involve boasts. Maybe he's saying that life is a mixed bag, that despite his privilege, things don't always go well. Charm and dissonance. Women leave, diseases happen. I can identify.

"Really." He extends his hand. "Charlie Byrd."

"You related to the Big Guy?" I'm referring to Senator Byrd, West Virginia's man in Washington, whose longevity has brought us equal measures of pride and pork and embarrassment.

"Not really," says Charlie. He eases two stools closer and looks over his shoulder. "Sort of. My dad's cousin. He was at reunions when I was a kid."

There's a lull as Charlie looks around for his drink, finds it, slides it down the bar. I drink more of my beer.

"He's not rich like we are. You know, big rich."

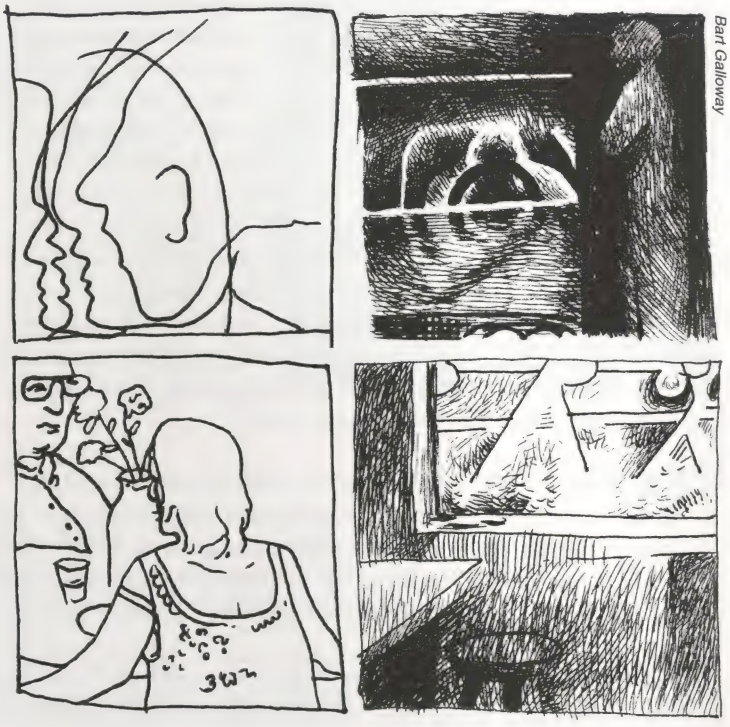
He drains his glass, shivering from Scotch or whiskey or whatever, and I drain mine. I raise my finger for another, and the bartender sees. Of course. He is there to dispense our calm.

"I was talking about dissonance," Charlie says, like he just remembered where we started. "You know, disharmony?" Like I don't know the meaning of the word. He gets his fresh drink and breathes deeply as he raises it to his lips.

"Gotchya," I nod, sipping my beer. This one will be my last—time to go home.

"Some stuff is just the way it goes. Like my cousin always comes around—I have this, like, fishing camp where I actually

He thinks the man has had too much drink, but he pours anyway, his face studied disinterest, the purest conspiracy between pusher and addict.



Bart Galloway

live now Cindy's gone. Really just a trailer beside a stream, and my cousin Joey comes by asking for money. He's a pain in the ass."

He smiles tightly and flicks his hand over the bar as if he's dusting off irrelevant distractions. I think about how, in West Virginia, the very rich and the very poor are so very close.

"Thing is," Charlie says, "different distractions. Different things, I should say. There are distractions, and then there are dissonances. Cindy was my wife."

At last we were getting back to his sore spot. The feeling was growing that his story was nothing as mundane as his rejection of Cindy, or even her leaving him because he was a drunk. "She left?"

"You can say that. She had multiple sclerosis. You know what that is?"

I nod. I know more about MS than Charlie will, ever.

"I'd never heard of it." Charlie takes my silence for ignorance. "None of us ever had. They said it was real common. Lots of people have it."

Maybe he's saying that life is a mixed bag, that despite his privilege, things don't always go well. Charm and dissonance. Women leave, diseases happen. I can identify.

"Really?" I say, for lack of anything else. Down below the bar, out of his sight, I flex my right foot and feel it tingle, the numbness of the nerves, just to remind me. I wonder if it will work right when I get up to go.

"Well over a quarter million," he says. He swallows, hard, and I can see he's composing himself. "She starts to get paralyzed. She can't stand it. Neither could I."

"That's a lot of… dissonance." I'm speaking mechanically; I feel nothing.

"She… started the car one day in the garage. She kept it running. I found her six or seven hours later. I know I pushed her to it. I must have."

I don't say anything, not about despair I've also felt or how I imagine the blue under her fingernails and fear it myself. I try to distance her fate and say nothing. After a few minutes, I delicately clear my throat. Charlie snaps alert.

"I have to go," he says and pushes back, rising from the bar. He calls a cab.

Once he is gone, I order another beer. I ask for a shot also. My eight dollars is gone, but I have more. Maybe I'm charmed after all. N&T

Geoff Fuller lives in Morgantown, W.Va., where he works as an editor. "This is the Life" is part of a collection that uses a mixture of prose poems, short fiction, and creative nonfiction to explore experiences with multiple sclerosis, provisionally titled "On Balance." He has also written crime novels that have garnered both prizes and rejection letters.

After the Wreck

When the paramedics lift my body
through the window of my car
I do not yet know I will live.
From car to ambulance, I take it all in:
pre-twilight sky, humid air
breathed in slow, painful sips.
I do not want to be surrounded
by helpful strangers asking what hurts.
Everything.
Hurts.
In between questions, I ask them to call my mother,
to call my friends who live less than two miles away.
Before leaving home, I told my dog
I'll be right back.
Now she waits, like only dogs can wait,
the only being who would have to live truly without me.
These professionals are not trained to know
familiarity could save me, one face
whose eyes have met mine in shared laughter.
As their actions slow, I relax,
believe my life is not yet over,
wait to hear what is broken, what will heal.
When I return home, my dog smells what has happened;
Mother makes a bed on the sofa.
We will live this way for months.
Every Saturday twilight reminds me:
Anything can be broken.
Every morning I wake,
each bone singing some new song.

—Donna Doyle

Donna Doyle earned a bachelor's degree in creative writing at the University of Tennessee, Knoxville, where she was the recipient of the Knickerbocker, Woodruff, and Women's Coordinating Council awards. Her poetry has appeared in Coffeehouse Poet's Quarterly, Phoenix Literary Arts Magazine, *Miriam Press'* Up Against the Wall, Mother!, *and* All Around Us: Poems from the Valley. *She has also received recognition in the Libba Moore Gray and New Millennium Writings competitions. This poem is one of a series written while recovering from a head-on collision caused by a drunk driver in 1998.*

ESSAY

Beyond Control

Caring for a Body with Diabetes

By Jeff Powers-Beck

Asking the impossible can make living with a chronic disease even more taxing.

I've lived with Type 1 diabetes, more or less successfully, for thirty-two years now, ever since I was diagnosed at the age of four. I still remember the morning my mother took me to the doctor's office. My dizzy spells and bouts of thirst had worried her more than a little. That morning, I had a big bowl of Captain Krunch for breakfast, and my blood sugar must have reached stratospheric levels.

In those days, they called it "juvenile diabetes." All injections were given in glass syringes, which my mother sterilized dutifully every morning and evening. I can still hear the tinkling of the glass syringe against the sides of the glass double boiler. Tink-a-tink-a-tink-tink: time for your morning shot.

Thirty-two years later, I feel fortunate. I'm married, have two beautiful children, and a terrific job. My health and fitness are quite good: I'm not having any difficulties with my retinas or my kidneys, and my circulation, blood pressure, and cholesterol levels are just fine. I haven't suffered diabetic neuropathy, the persistent burning that many with diabetes come to feel in their hands and feet due to nerve damage, or impotence or any other long-term complication—except one. I've lived a life under the linguistic onus of *control,* a matter of medical verbal malpractice I've grown to resent.

You see, when I was first diagnosed with diabetes, doctors told my mother that she needed to be sure that my diabetes was "controlled." And for many years since then, I have heard the same questions from doctors, nurses, and dieticians: "Is your diabetes *under control?*"

"Are your blood sugars *under control?*"

"Are you *controlling* your diet?"

"How is your *control?*"

Or, more baldly, "Are YOU *under control?*"

In *Learning to Live Well with Diabetes,* a popular book on diabetes care, its author, nurse Judy Ostrom Joynes, assures parents that "with optimal blood glucose *control,* children with diabetes follow the same growth... patterns as those without diabetes. When blood glucose is carefully *controlled* before and

Courtesy of Jeff Powers-Beck

Jeff Powers-Beck, holding daughter Eleanor, prefers a language geared to care of his body rather than control of his illness. He has lived with Type 1 diabetes since he was diagnosed at the age of four.

Courtesy of Jeff Powers-Beck

Jeff Beck (second from right in front) and his twin brother, Brian (third from right in the back), attended the Hertko Hollow Camp in Boone, Iowa, for children with diabetes during the early 1970s.

during pregnancy, outcomes for both mother and baby equal those in women without diabetes. There is also strong evidence that careful *control* of blood glucose prevents development of long-term complications." Joynes' approach to blood glucose monitoring is named (What else?) "pattern control."

Although I have often been impressed by the genuine care of my medical professionals, it has been hard not to think of them as control freaks.

In defense of the control freaks, I have to say that their intentions and practical counsels are excellent. They are helping people with diabetes to maintain blood glucose levels as close as possible to normal, which will lengthen life and improve its quality. They are seeking, with care and dedication, to reduce the complications that too many suffer: the amputations, the kidney dysfunction, the blindness, the pain, the heart disease.

The controllers have all the facts, studies, and statistics on their side, which are really incontrovertible. My only—but important—objection is that the clinical language of control is inhumane.

I BRISTLE AT THE WORD *CONTROL*. IT IS A VERY HARD AND COLD WORD TO APPLY TO SOMEONE ELSE'S BODY AND LIFE.

It is an abiding mystery to me why persons with diabetes are among the very few on whom medical professionals inflict the language of control. Health care providers tell people with hypertension to monitor their blood pressure and to take their medicine, but they don't tell them to "control" their systolic and diastolic levels. Practitioners tell people with heart disease to watch their triglycerides and lower their cholesterol levels, but they don't instruct them to "control" them. Doctors, nurses, and dieticians counsel people with chronic obesity to follow their diets, but they're not ordered to "control" their metabolism. Only we, it seems, the sufferers of *zuckerkrankheit,* are enjoined constantly to control our disorderly bodies.

As a professor of English, someone who cares a great deal about the sounds and meanings of words, I bristle at the word *control.* It is a very hard and cold word to apply to someone else's body and life: cold as an icy stethoscope and hard as a laboratory surface.

The word *control* rings with a puritanical absoluteness. "Are you *under control?"* sounds like something Hawthorne's bitter, cuckcolded Roger Chillingworth might say to his scarlet-lettered wife, Hester Prynne. The assumption seems to be that we are "out of control," backsliders or rank sinners.

Or, if it's not said with the lip-smacking tone of moral superiority, the word thuds with the frigidity of scientific positivism which treats all life as objective, biochemical phenomena: "Does your blood glucose exceed the *controlled* level?" The speaker has long since lost sight of you as a person. Instead, your body is viewed as a controlled experiment, an opaque receptacle for blood glucose, as a test tube more or less. These are the doctors, I suspect, who order manifold tests, seize your vital fluids imperiously, and only share the results with you, almost accidentally, months later. Why, after all, bother consulting with a test tube? Do blood glucose experiments have feelings?

And then I am reminded of what Shakespeare's Shylock said of another very "controlled" group, the Jewish people of Renaissance Europe: "If you prick us, do we not bleed! If you tickle us, do we not laugh!" All of us with diabetes, who have pricked our fingers numberless times for glucose tests, know, feelingly, the answer to the first question. And, yes, most of us laugh when tickled.

I'VE LIVED A LIFE UNDER THE LINGUISTIC ONUS OF *CONTROL,* A MATTER OF MEDICAL VERBAL MALPRACTICE I'VE GROWN TO RESENT.

Of the two insulting uses of *control,* I find the puritanical one less grievous than the positivistic. I'd rather be called a reprobate than a test tube, for sinners at least have feelings, of which controlled experiments are incapable. Even if I could *control* my body, I'm not sure that I would want to do so. I would much rather *care*

for it. Indeed, I think professional diabetes education can be improved considerably if it employed a language of care in place of the language of control.

As a professor of the humanities, I cannot help but ask for doctors to speak to me about my blood, body, and life in a humane fashion. So here, if any doctor, nurse, or dietician is listening, are some counsels to aid them in their attempts to speak a language of care.

Instead of asking, "Are your blood glucose levels under control?" say, "How are you caring for your blood glucose?" or, more prosaically, "What do your blood glucose levels average?"

Instead of inquiring, "Are you in good control?" say, "How well are you caring for yourself?" or more bluntly, "Would you tell me about your health and blood sugars?"

Instead of saying, "Is your diet under control?" try, "How well are you managing your diet?" or "Are you able to follow your meal plan well?"

I'D RATHER BE CALLED A REPROBATE THAN A TEST TUBE.

And instead of advising that "good diabetes control will reduce your chance of complications," point out that "good diabetes self-care will improve your life."

Although *control* is but a word, it is a word that puts health care professionals and patients with diabetes in an adversarial relationship. When all the doctors and the patients can speak of *care* rather than *control* and when they consider insulin, diet, exercise, and blood glucose monitoring as part of a *self-care* regimen rather than a *controlled* regimen, then considerable progress will have been made. We will all be beyond controlling our diseases, and we will be able to start caring for our bodies and, just maybe, caring a little bit more for one another as well. N&T

Jeff Powers-Beck is associate professor of English at East Tennessee State University. He has published a book on 17th-century British literature entitled Writing the Flesh: The Herbert Family Dialogue. *He is also an avid baseball fan.*

WHY IS JUVENILE DIABETES "BEYOND CONTROL"?

Before Canadians Frederick Banting and Charles Best's discovery of insulin in 1921, most juvenile diabetics died within a year or two of diagnosis. Today, they are able to outwit their own bodies and live on into adulthood. Living a "normal" life, however, takes a lot of work.

There are two main related chronic diseases that share the name *diabetes.* In both, the body's production or response to insulin has seriously malfunctioned. Generated in the pancreas, insulin is the hormone that allows sugars, the common name for glucose, to enter the cells. There glucose powers all cellular functions; glucose is the end product of the breakdown of the carbohydrates contained in a wide variety of foods, from table sugar to pastas. If sugar remains trapped in the bloodstream, the person dies of starvation.

The far more rare Type 1 diabetes, accounting for only 5 to 10 percent of the 16 million diabetics in this country, is an autoimmune disease. For reasons that have to do with some as yet unfathomable accident of genetics and circumstance, the body's immune system mistakes the pancreas' beta cells, the site of insulin production, for foreign bodies and destroys them. Type 1 often goes by the name of "juvenile" diabetes because it most frequently manifests itself between the ages of 10 and 14.

Type 2, or adult-onset, diabetics can manage with oral medications for a time. For juvenile diabetics, however, almost invariably as soon as the diagnosis is made, there are two or three or four injections of insulin administered daily with very fine needles just under the skin. Or they receive insulin by means of a pump which delivers the hormone continuously through a tube and needle inserted, again just under the skin, in the person's abdomen. Before each meal and at bedtime, Type 1 diabetics prick a finger, squeeze out a droplet of blood, and test it with a small meter; the meter displays a numeric value—ideally somewhere between about 80 and 140 milligrams of glucose per deciliter of blood—that measures the "blood sugar." Blood sugar is quite simply the concentration of glucose circulating in the bloodstream.

Ideally juvenile diabetics constantly measure and monitor their ingestion of all carbohydrates: from the simple table sugars found in sweets to more complex sugars contained in fruits, some starchy vegetables, milk, breads, and pastas. Especially in the case of diabetics who deliver insulin by injection rather than with the pump, each of their three meals and several snacks are carefully timed and the amounts calculated to increase the odds of there being just the right amount of insulin present to allow the sugar in the blood to pass into the cells. Diabetics on the pump have a little more latitude in terms of timing, but they still need to follow a healthy diet, and when they sit down to eat, they must gauge how many carbohydrates they are about to consume so they can dial in an extra dose to process the meal.

Type 1 diabetics can follow this demanding regimen to the letter and still find themselves in trouble—and this is why thinking you can "control" diabetes is just asking to be frustrated. For while Banting, Best, and their colleagues made it possible for diabetics to replace the missing insulin, they still can't replicate the exquisitely sensitive, complex feedback system that regulates the hormone. That system responds to the presence or absence of food, as you'd expect, but it also reacts to changes in activity, to even mild illnesses, to turbulent physiological states such as puberty or pregnancy, and to emotional stresses, both good and bad. Then there are those instances when the blood sugar surges or drops, sometimes to dangerous levels, for no easily discernible reason. These sudden changes can be due to subtle changes in activity level, to insulin trapped in subcutaneous layers of fat, or to the sometimes unpredictable actions of long-acting insulin. But often you simply can't even guess at the cause.

Juvenile diabetics, then, have to be on the alert for signs for hyperglycemia

or "high blood sugar" (feeling unusually tired, thirsty, having difficulty concentrating, or experiencing frequent urination, to name a few), which happens when there is too little insulin. Or they watch out for hypoglycemic or "low blood sugar" symptoms (feeling hungry, dazed, shaky, or silly, among others), which occur when there is too much insulin. If they pick up the presence of an imbalance early enough, they can bring down hyperglycemia with insulin or treat the hypoglycemia with fast-acting sugar before they land in serious trouble.

If there's any change in the routine, they do their best to compensate and hope for the best. Exercising more than usual? They eat extra snacks and test frequently. Ill? They do their best to tame the wild swings in blood sugar that can result. Traveling? Just keep pricking your finger, increase or decrease the short-acting insulin as needed, and always bring enough food so that if you're stuck on the runway, you can improvise something that looks like a meal. It often feels like trying to walk a tightrope in the dark.

The stakes are considerable. If diabetics chronically err on the side of high blood sugar, they develop over time all those gruesome complications: blindness, kidney failure, impotence, cardiovascular disease, and nerve damage, poor circulation, or infections which can lead to lower limb amputations. Even those who carefully manage their disease may only be delaying the onset of such side effects. But if they do manage their disease carefully in an attempt to avoid long-term complications, they court those very rarely fatal but still frightening hypoglycemic episodes during which they descend into a netherworld as the sugar-deprived brain begins to close up shop.

Is it possible to control diabetes? No, not really. But today, especially with the help of vastly improved home monitoring devices, it is possible to manage the disease when it's in the mood to be managed. And it allows itself to be managed often enough to allow people with Type 1 diabetes, a once invariably fatal malady, to live on into adulthood and old age.

— JHW

To An Old Friend

Decades ago, stooping over
the pickled flesh in anatomy lab,
formaldehyde burning our eyes,
we might have been crying, but we
knew those tears were false.

We laughed through those hard years,
listened for murmurs and rales,
learned the red maps at the back of the eye,
the singular breath of the diabetic,
the names of all the wrinkles in the brain,
then briefly stopped to map
the heights we'd scaled together.

Too soon we went out in the world
and lost touch, neither wrote nor called,
found our lives and loves in backwater towns,
occasional notes in the Alumni Review
the only signs of our passage.

I never imagined I would learn of your death
on this cold day when I chanced to meet
a man from your town in a fly shop
in Colorado. The dread on his face when
I asked about you sent a tingle around
the hub of my heart. "You must not
have heard," he said. "He died
two months ago:
lymphoma."

Today the trout refused to rise
to the gray sky, instead took midges
at the bottom of runs. Some I lost
to distraction, some broke off
the thin tippet. But one I landed
was a fine green bronze, flanks blazing
with the rainbow's promise. I thought
of you, old friend, as I held him
gently in the violent water, then
gave him back to the stream.

— Jim Britt

Jim Britt, a radiologist, has lived in Knoxville, Tenn., for 25 years. He is a graduate of the University of Mississippi Medical School. Britt has work forthcoming in Cumberland Poetry Review.

Reviews

Icy Sparks
by Gwyn Hyman Rubio
Viking
New York - 1998
$24.95 (hardcover)

Icy Sparks has a secret. She is given to fits — not the kind where you get down on the floor and scream and kick or the kind where you slip into a state of open-eyed unconsciousness. Icy is given to croaking, jerking, and spewing forth verbal filth. She has Tourette Syndrome, a neurological disorder little known in 1956 when 10-year-old Icy lives in Poplar Holler in Eastern Kentucky with her grandparents. She manages for a while to get to the root cellar or to the barn to have her fits in solitude. Once her propensities come to light, however, there's hell to pay.

And pay she does. She is forced into isolation — removed from her fourth-grade class to sit alone and read in a supply room, removed from her home and taken to an asylum in Lexington, Ky., and later removed from any interaction with neighbors and townspeople, except for Miss Emily, who is equally isolated in a fortress of fat. If all this sounds too dreary to warrant picking up the book, fear not — there are croaks of humor, too, in Gwyn Rubio's first novel.

Icy thrives on attention from other people and gets star treatment from her doting grandparents and Miss Emily. Otherwise, her world is filled with people who give her the wrong kind of attention, such as her sadistic fourth-grade teacher, or unwelcome attention, such as her crush-struck classmate, Peavey Lawson. Locked in the asylum with children whose disorders are more glaringly obvious than her own, Icy recoils from them and from the implication that her presence there means she, too, is as repulsive and freakish as she finds them to be. Before she leaves the asylum, she learns a lesson in tolerance, a lesson the other residents of Poplar Holler *haven't* learned, as their treatment of Icy shows when she comes home.

Hayward Wilkinson

Gwyn Rubio's first novel, *Icy Sparks,* looks at the effects of Tourette Syndrome on an Eastern Kentucky girl in the 1950s.

Isolation can make you mean. Icy resents being shunned, and she turns that resentment against the two people who love her most, her grandparents. In this, she is not unlike most youngsters. What adolescent doesn't writhe in the agony of real or perceived difference from peers and in turn punish his or her own family? Icy finds surcease from her agony the same way most adolescents do: She falls in love. And here begins the freshest, funniest, most enjoyable part of the book. Icy melts and moons about, writing highfalutin love letters to a beau who receives them gladly but whose prosaic nature leads him to interpret them in an often hilarious light.

Icy's true liberation comes like lightning, bringing her into a circle of love and acceptance and turning her froggy voice from curse to gift. When Icy finally learns that her urges to jerk and croak and curse have a medical basis, it doesn't really matter to her because she has come to terms with who she is.

Rubio has created a wide array of characters, the most engaging of which, ironically, are minor ones, like Mr. Wooten, the principal. His jumbled sympathy and impatient perplexity about Icy make him seem more three-dimensional than most of the larger characters, who remain types for most of the book. Another minor character, Mamie Tillman, is so intriguing that the reader's eye quickens whenever her name appears on the page. Laudably, Rubio has placed her people in an Appalachia that is neither romanticized nor given the Tobacco Road treatment.

In the prologue, each of Icy's grandparents gives a lengthy, lyrical account of how she came to be born such an odd, froglike child. In the rest of the book, however, they trickle out ungrammatical and down-homey bits of wisdom. They and Miss Emily sometimes seem to be hyperaware of the reader and converse in the self-conscious, self-promoting way people do in a restaurant when they know the stranger at the next table is eavesdropping. Being that stranger at the next table is more fun — and the talkers more believable — when they don't know you're listening. If we're lucky, Rubio will take us back to Poplar Holler and give us a chance to eavesdrop on Mr. Wooten and Mamie Tillman.

— Laurene Scalf

Laurene Scalf reads (a lot) and writes in Louisville, Ky.

Sweet Invisible Body: Reflections on a Life with Diabetes
by Lisa Roney
Henry Holt and Company
New York - 1999
$23.95 (hardcover)

"It is difficult to speak the truth of illness," writes Lisa Roney, who was diagnosed with Type 1, or juvenile, diabetes just before her 12th birthday nearly 30 years ago. But in *Sweet Invisible Body,* that is just what she does. What she offers is her own personal truth about living with diabetes, but there is enough here that resonates with those of us who live with this disease — and those of us who don't — to both comfort and unsettle.

I did not pick up this book simply because Roney comes from a family of "tough, practical" people with roots in both the craggy mountains of Appalachian East Tennessee and in West Tennessee's Mississippi Delta or because she spent her childhood living in Knoxville off and on. I sought out this volume because my husband and I have a child who, to our complete astonishment, was diagnosed with juvenile diabetes three summers ago at the age of 10.

Juvenile diabetics cannot metabolize carbohydrates, or sugars, because they

have lost the ability to produce a critical hormone, insulin, that allows the sugar to exit the bloodstream and enter the cells where it fuels life itself. Left to themselves, their bodies would starve to death. It is an incurable condition, but—if you follow a complex regimen involving frequent testing, insulin shots or the use of an insulin pump, diet, and exercise—it's survivable.

One of the things I most appreciate about Roney's account is how accurately she portrays the way it feels to manage this tricky disease day in and day out. Although diabetics can replace the insulin they're lacking, they cannot as yet duplicate the exquisitely sensitive mechanism that keeps the hormone in balance with the amount of sugar in the blood. Too much insulin results in potentially life-threatening hypoglycemia as the brain shuts down for lack of sugar. Too much sugar over time results in hyperglycemia, which eventually leads to blindness, kidney failure, nerve damage, and cardiovascular disease.

All kinds of things—exercise, stress, and illness, to name a few—can affect the often-precarious equilibrium. Juvenile diabetics—and their parents—are left to try to balance this crucially important equation as best they can. "Diabetes affects almost everything a person does," states Roney matter-of-factly. It is "a constant balancing act, with adjustments of insulin dosage, constant calculations about food and exercise, about whether a given interaction is worth the energy, about the timing of every walk, jog, movie, lecture, airline flight, nap, phone conversation, and meal." When there are so many people who think that coping with diabetes mainly involves jabbing yourself with a needle and avoiding sweets, it is a comfort to read the words of someone who truly understands.

Even before diabetes came to live at our house, I had been fascinated with illness narratives because, I've decided, they reveal to us the intricacies of what I think of as the truly primal relationship: the often uneasy alliance between who it is we imagine ourselves to be and the actual physical body that makes our existence possible. Roney's story does not follow the usual arc of such illness narratives: a life shattered by a chronic, and/or life-threatening disease, the descent into pain, confusion, and frustration; the triumphant re-creation of a life that is deeper, more profound, and truer than the old one.

Instead, in a series of essays divided into three parts whose titles include, appropriately enough, the names of carbohydrate-laden foods (chess pie, malted milk shakes, a knot of chocolate-covered pretzels), Roney tells of a child and a family who promptly rolled up their sleeves and set to work. "I knocked the air from the syringe, popped it into my leg, withdrew it efficiently. I did what had to be done, no more, no less, in one family tradition I could still maintain: practical perseverance." For a good 15 or 20 years, she soldiered on, following the party line: "You can do anything you want to do, as long as you control the disease rather than letting it control you."

Only in her 30s—after years in therapy trying to deal with depression, her parents' divorce, and her own troubled love life—did it occur to her that she might not be in control of her diabetes, that it might in fact be exerting a good deal of influence over who she was and how she lived. She began to ask herself the question that rests at the heart of the book: "How can a condition that affects nearly every tissue and substance in one's body not shape the personality, albeit differently in every individual, in a back and forth or round and round that is much like the dance of lovers themselves?"

At long last, she breaks out of denial and begins her descent into the deeper

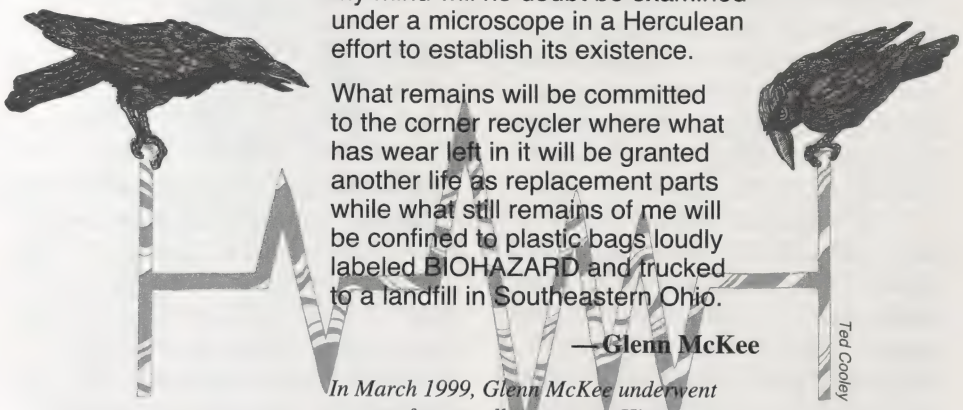
A Crowd of Quiet

A crowd of quiet storms down
the 3 North hallway. Half-asleep,
I wonder if death has come to take
me to the elevators then to Surgery
where my parts will be separated
by a Certified Theological Surgeon
and my Spirit shipped to Spiritland,
my Soul sent to its Just Deserts.

My mind will no doubt be examined
under a microscope in a Herculean
effort to establish its existence.

What remains will be committed
to the corner recycler where what
has wear left in it will be granted
another life as replacement parts
while what still remains of me will
be confined to plastic bags loudly
labeled BIOHAZARD and trucked
to a landfill in Southeastern Ohio.

—Glenn McKee



Ted Cooley

In March 1999, Glenn McKee underwent surgery for ampullary cancer. His poem, "Memory's Menu," placed second in Now & Then's *1998 Appalachian Poetry Competition. That poem also appears in* Memory's Menu, *a volume of McKee's poetry published in April 1999, by Mellen Poetry Press.*

meanings and costs of a life with diabetes. She proceeds to explore how the disease has affected her perceptions of her own body, and, in particular, her sexuality. She investigates her struggle to live alone, to achieve autonomy while coping with a disease that keeps her dependent, especially on her mother who still calls her every morning to make sure she hasn't lapsed into a hypoglycemic stupor. She ponders her ability—or inability—to form intimate relationships with her family, her friends, and her lovers; her attempts are thwarted by her fear of imposing the disease's restrictions on them and by her sharp awareness of how diabetes has set her apart.

As I made my way through *Sweet Invisible Body,* I felt a growing sense of dismay. "Oh please," I thought, "I hope it all doesn't matter *this* much." My suspicion is that after years of denying that diabetes had any impact on the person she was and the life she led, she's swung too far in the other direction. If the good glucose fairy came down, turned back time, and gave her back an existence that had never been touched by diabetes, I would venture to guess that many of the problematic aspects of her life would remain. Even she acknowledges the possibility that "perhaps my illness only gives me a retrospective excuse for a personality I would have had no matter what." But even if she overstates the impact of her illness, I value this book because she acknowledges that such an impact exists, and it is profound. It does become impossible to sort what a chronic disease has injected into a life and personality and what would have been there in any case. It's not something I've often seen acknowledged.

It is a wonderfully written book. On page after page, I found statements that captured with great clarity the curiously paradoxical experience of living with this disorder. "When I was younger, I only knew that I had to think about diabetes every minute of the day in order to maintain the appearance of not being ill at all," she reports, exaggerating only slightly. I came to her observation that "the fact is... that I am both ill and healthy, supposed opposites that we often have trouble holding in our minds at once. I need to be able to hold both these self-images together, or I cannot know myself." Yes, I thought, that's exactly right.

But *Sweet Invisible Body* is a book worth reading even if you don't have firsthand experience with the disease. The reality that diabetics face head-on is one that we all have to acknowledge. Toward the end of the book, she writes, "Diabetes is like this: one loss after another, year after year, with constant anticipation of more, a narrowing path of health and activity." Substitute "old age," a prospect that becomes less theoretical for those of us in middle age, and you realize that walking down that narrowing path is a journey most of us will have to take if we manage to live long enough. We all live in bodies programmed to self-destruct, that do not have what we consider to be our best interests at heart. We all need to assimilate this hard truth. Juvenile diabetics just happen to learn this lesson at a very young age.

— Jane Harris Woodside

Jane Harris Woodside is the mother of three children, one of whom is living with juvenile diabetes. She is also editor of Now & Then.

Kate: The Journal of a Confederate Nurse
by Kate Cumming
Edited by Richard Barksdale Harwell

Louisiana State University Press
Baton Rouge, La. - 1998
(reprint of 1959 edition)
$16.95 (paper)

Kate Cumming's journal chronicles the conditions found in Confederate hospitals—many located in Appalachia—and the plight of those who received care there. Through her diary, we see the darkest side of the Civil War: ill-equipped, makeshift hospitals, the constant moving of extremely ill and mortally wounded patients, the lack of basic medical resources. Her account supports remarks made in 1940 by prominent Civil War historian George W. Adams that "the Civil War was fought in the very last years of the medical middle ages.... Physicians trained in the old attitudes were trying desperately to meet the gigantic problems of military medicine and surgery with such means as they could command." Her descriptions of the soldiers' wounds and the medical treatment they received left me flabbergasted and horrified at times.

Cumming was an extraordinary woman who followed her heart into service in the Confederate Army as a nurse. Her journey along this most difficult path spanned three years and led her through the Southern Appalachian region: Tennessee, Georgia, and Alabama, as well as parts of Mississippi. Obviously a well-educated woman, her training was not as a nurse but rather it was designed to equip her for her future as a genteel woman of wealth in a Southern society. She volunteered over the protests of her family. Steadfastly maintaining that the Civil War was her cause as surely as it was the men's she attended, she believed that since she could not fight, she must take care of those who did. Though illness caused her to go home several times during the war, she would not be dissuaded from returning.

To be a nurse during the Civil War—for the Union or the Confederacy—was not to occupy an elegant or elevated position. When Dorothea Dix was appointed superintendent of "female nurses" for the Union Army in 1861, she circulated a recruitment brochure that read: "No women under thirty years of age need apply to serve in government hospitals. All nurses are required to be very plain looking women. Their dresses must be brown or black, with no bows, no curls, no jewelry, and no hoop skirts." The hours were long, the work grueling and endless. The nurse often performed her duties despite rudeness and ingratitude. Time and again, the women heard the doctors express the opinion that there was no room in the army for them.

In actuality, Cumming's duties were more culinary than medical. Her diary speaks of her daily challenge to procure milk and fresh vegetables and fruit. Cooking itself was a formidable task. The hospitals were set up in homes commandeered by the Confederate Army, homes usually containing inadequate and inconveniently arranged kitchens. Yet she managed to cook and serve nutritious fare

to her patients. As she made the rounds of her ward, serving her food, she adopted a holistic posture. She talked with the men, offered words of comfort and encouragement, took dictation, and sent letters to men's families.

In her former life, Cumming most certainly had to have been sheltered from the very things with which she came into daily contact on the Confederate front: death, brutal injury, illness, suffering of incomprehensible magnitude, disfigurement, maiming. A particularly heart-rending entry speaks to a time she made rounds at a new hospital site with one of the surgeons. The tent was nearly 100 feet long and filled to capacity. Every soldier there had undergone an amputation. Through her narrative, we come to realize that amputation was synonymous with death in the early days of the war. Her anguish and sense of helplessness are palpable as she writes of surgeons having no bandaging materials and improvising with strips torn from tents to bind wounds.

Her accounts are, for the most part, amazingly empty of self-pity or indications that she was shocked or traumatized by the sights, smells, and realities she encountered. Cry she might have, but action is what she recorded. In addition to all her other tasks, she wrote countless letters home and to contacts, soliciting funds and materials.

Her dedication to documenting her daily events is commendable. Her duties would have been enough to completely fill 24 hours, yet she disciplined herself to pen these notes frequently. In the end, she stated that her words "feebly indicate, and only faintly picture, the sad reality."

This book is not a "quick read." It is often wordy and burdened with unnecessary detail and opinion. But still, it is a chronicle of an emerging profession and of women carving out their place despite great odds and much prejudice. It is an important book which reveals the mindset of a Southern woman on topics of the day: slavery, the evils of war, loyalty and determination. There are themes that emerge, words that are timeless, that take us beyond the Civil War and cry out to be heard by every society who has men and women returning from war: "The War has left thousands of our men almost as helpless as they were in infancy... there will be very little care bestowed on them. Is nothing to be done for these heroes? It is not charity to care for them, but a sacred duty."

No doubt Cumming entered the medical corps under great illusions which were shed as she grappled with daily reality. Once I had finished the book, I found myself vividly recalling words written in only her second month of service, and I hoped she felt the same at the end of her tenure: "We have seen many sad sights and much suffering since we came to this place; still, I shall ever look back... with sincere gratification, and feel that I have lived for something."

— Elaine Fehringer Leone

Elaine Fehringer Leone is a professor of occupational therapy at Eastern Kentucky University, Richmond, Ky. She primarily teaches content in the area of infants and young children. A "transplant" to Appalachia from Wyoming, Leone became fascinated with Appalachian studies and folklore through teaching fieldwork in Eastern Kentucky.

Midwifery and Childbirth in America

by Judith Pence Rooks

Temple University Press
Philadelphia - 1997
$69.30 (hardcover) $34.95 (paper)

Childbirth practices in the United States differ considerably from those in many other countries, including Europe, Canada, Australia, New Zealand, and Japan. Childbirth in the U.S. today is a series of high-tech medical interventions, such as the artificial induction of labor and continuous electronic monitoring of the fetus. Because of this, the cost of care has increased, yet the outcome of that care is not as favorable in the U.S. as it is in many other industrialized nations.

Historically, midwives in other nations have contributed greatly to overall health, lowered costs, and preserved the quality of care. In her book, *Midwifery and Childbirth in America,* epidemiologist and certified nurse-midwife Judith Pence Rooks points out that although capable of providing cost-effective, high quality care, U.S. midwives provide much less in the way of health care than their foreign counterparts. She thoroughly explores the issues surrounding the public perception and the practice of midwifery in this country from both a historical and a sociological perspective.

During the U.S.'s first 250 years, midwives attended most childbirths. At the outset, in colonial America, most midwives were British-trained or educated in Europe, but as the frontiers expanded, untrained members of the community filled in as the need arose. With no schools available to train midwives until the late 1800s, the practice of midwifery in this country was based mostly on experience and handed down from one generation to the next.

Many Southern plantations had one older female slave responsible for "birthing" both the black and white babies. In addition, older widowed women of the community also provided care in many cases. Although very dedicated to their work, these "granny midwives" were uneducated, and their practice was often filled with superstitions that have persisted in the Southern and Appalachian regions of this country. A fact not acknowledged by Rooks is that "granny midwives" provided care in Eastern Tennessee and Kentucky well into the 1980s. It was the uneducated, poorly prepared "granny midwife" who became symbolic of midwifery in the United States.

In 1914, Frederick Taussig, a concerned physician, suggested that nursing would be an ideal background for women aspiring to become midwives. In 1925, Mary Breckinridge took Taussig up on his suggestion when she opened the Frontier Nursing Service in Hyden, Ky. The story of Mary Breckinridge and her service to the people of Leslie County, Ky., is one of the high points in Rooks' book. It marked the beginning of nurse midwifery in the United States. Sixteen of Frontier's early graduates formed the first American Nurse Midwifery Association in Kentucky; by 1954, this association became the American College of Nurse Midwives. The Frontier Nursing Service still serves in cooperation with Case Western Reserve in Cleveland, Ohio, by preparing nurse midwives at the master's level to

serve special populations in this country.

Southern and Appalachian regions of the United States hold a rich history of childbirth practice. While Rooks pays tribute to this history in the earlier chapters of her book, she fails to mention many of the colorful stories of the area. Instead, she focuses on the part of the country where she chose to settle, mostly in California and the Western regions, particularly the Indian reservations.

The stories she does tell about Appalachia and Tennessee, in particular, other than the founding of the Frontier Nursing Service, include a section on the 1980 hearings about the obstacles to midwifery held in Nashville, Tenn., by Al Gore, then a congressman. She also discusses "The Farm," a commune begun in middle Tennessee's Summertown by Stephen Gaskin and his wife, Ina May. May served as a midwife and later wrote the book, *Spiritual Midwifery,* which sold over a half million copies. Unfortunately, Rooks does not mention the opening of birth centers in the East Tennessee area in Sweetwater and in Knoxville, both of which are run by nurse midwives.

All in all, Judith Pence Rooks provides a well-written explanation about the evolution of childbirth practices in the U.S. There is an underlying tone of disappointment about the opposition to nurse midwifery by the medical community, especially in relation to underserved areas. However, Rooks does a good job of getting her point across without undue criticism of her opponents. She ends with recommendations from both professional and consumer groups and a plea for her understanding of the practice of nurse midwifery and its place in the U.S. health care system.

— Molly Meighan

Molly Meighan is an assistant professor of nursing at Carson-Newman College in Jefferson City, Tenn. She has many years of experience in maternity nursing. Before coming to Carson-Newman in 1996, Meighan served as the coordinator for the East Tennessee Regional Perinatal Program, developing a high-risk referral system for women with complications of pregnancy. She was also the clinical director for obstetrical nursing at the University of Tennessee Medical Center in Knoxville, Tenn.

The Chinese Poet Awakens
by Jeff Daniel Marion

Wind Publications
Lexington, Ky. - 1999
$12.50 (paper)

No one ever confused the brutal and corrupt Italian noble who proudly points out his last duchess painted on the wall with Robert Browning who wrote the poem about him. It is hard to think that anyone identified Tennyson with the speaker of his "Ulysses." But the case is not always so plain.

Don't we suspect a close relationship between the poet T.S. Eliot and his J. Alfred Prufrock? Isn't it more than possible that John Berryman is both Henry and Mr. Bones? Who is Ted Hughes' Crow besides Ted Hughes?

A poet may choose to create a persona that lies so contiguous to the contours of his or her own personality that poet and persona might almost be identified with each other. Almost, but not quite — for if there were not some important differences, the poet would not go to the trouble of erecting a separate persona. The "I" would serve well enough.

After all, much is lost when the first person speaker is no longer the poet's avowed "I": We forego some of the edge of personal conviction, the ring of the words of the authentic witness. We lose the force of the direct gaze and must be satisfied with the sidelong look. Declaration may subside to murmur.

Yet much can be gained by employing a persona that slides into — and again out of — the poet's own personality. It is interesting to see what advantages Jeff Daniel Marion has found in attributing

Books Worth Mentioning

Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930 by Sandra Lee Barney (Chapel Hill: University of North Carolina Press, 2000; $39.95 hardcover, $17.95 paper).

Respecting Patient Autonomy by Benjamin H. Levi (Champaign: University of Illinois Press, 1999; $44.95 hardcover, $19.95 paper).

The Politics of Women's Health Care: Exploring Agency and Autonomy by The Feminist Health Care Ethics Research Network, Susan Sherwin, and others (Philadelphia: Temple University Press, 1998; $59.95 hardcover, $19.95 paper).

HIV/AIDS and the Public Workplace: Local Government Preparedness in the 1990s by James D. Slack with a foreword by Chester A. Newland (Tuscaloosa: University of Alabama Press, 1998; $44.95 hardcover).

One-Eyed Science: Occupational Health and Women Workers by Karen Messing (Philadelphia: Temple University Press, 1998; $59.95 hardcover, $22.95 paper).

Living with Spina Bifida: A Guide for Families and Professionals by Adrian Sandler (Chapel Hill: University of North Carolina Press, 1997; $45 hardcover, $19.95 paper).

I Can't Remember: Family Stories of Alzheimer's Disease by Esther Strauss Smoller (Philadelphia: Temple University Press, 1997; $24.95 hardcover).

In a Tangled Wood: An Alzheimer's Journey by Joyce Dyer (Dallas: Southern Methodist University Press, 1996; $22.50 hardcover, $12.95 paper).

Dirty Details: The Days and Nights of a Well Spouse by Marion Deutsche Cohen (Philadelphia: Temple University Press, 1996; $49.95 hardcover, $18.95 paper).

— Sandra L. Ballard

the verses in his handsome new volume to "the Chinese Poet."

His gains are considerable, I think, and may be illustrated by glancing at a brace of paired poems, "Late Autumn the Chinese Poet Invites His Old Friend the Brier Out to the River to Sit a Spell" and "In the Month of a Waxing Moon the Chinese Poet Says Farewell to the Brier." Reflecting the relationship of Marion and the recently deceased poet, Jim Wayne Miller, these poems have not only the extra interest of literary history but the fascinating situation of one persona addressing another persona.

Surely the most renowned persona in Appalachian poetry, "Brier" is, of course, Miller's creation. Miller was not Brier — or not entirely. He was a learned man, a professor of German literature, widely traveled but not an exile to the industrial waste heaps of Detroit or Flint or Pontiac, where Brier lives. Brier shared a great many sentiments with his creator — especially in the matter of broad politics — but his passionate vernacular speech is all Brier's own, not an idiom that belonged to Miller in print or in person. Brier was a spokesperson for a strong and consistent point of view.

The Chinese Poet is a different sort of entity; he embodies not a point of view but a certain mood of acceptance, of willing acquiescence, of quietude and solitary thoughtfulness. He exemplifies many of the qualities we associate with traditional Chinese poetry, with the work of Han Shan, for instance, who is present in this book as a tutelary master.

It requires more than one reading of "Late Autumn" to see that the Chinese Poet is not speaking to a present friend but to an absent one and that the invitation is not to go fly-fishing together but to recall a day out of the past when such an expedition took place. The bluebells were blooming then, and now the Chinese Poet thinks of the blue October sky as "a bell of blue clarity" whose peals draw the friends together, no matter what distance obtains between them. Wherever they are, however they are engaged, whatever they may be thinking at any time, there is a colloquy going on between them.

In the Chinese Poet's mind, their dialogue takes the form of a river; they talk "waist deep" in it and throw out their suggestions like lures to take the "golden-backed bass" or to glimpse the "sheen of rose-hued rainbow."

The companion poem, "Month of a Waxing Moon," recalls the river figure as the poet keeps up his end of the conversation:

For days I've watched the river,
cast my words over the water,
halfway expecting to see you wade ashore,
stringer heavy with the day's catch.

But the expectation cannot be literally fulfilled; the poem bears a dedication line, "In memory of Jim Wayne Miller." The day of bluebells is remembered again, but with keen wistfulness:

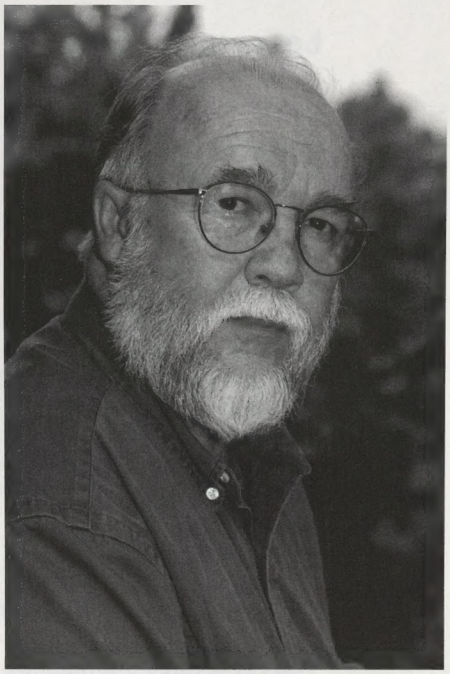
Now in the waning days of August
I see the first yellow-bronzed leaves
of the dogwood turn in the wind
and fall, swept away on forever's river.

Time passes; things dwindle and disappear; but the river — the exchange of the poets' minds — goes on forever. Just as their communion obliterated distance in the other poem, here it overcomes the separation of death.

The idea of the river as the communion of poetry is an organizing metaphor throughout the book. It occurs in the first poem: "Here is the river I love, wave upon / wave of words lapping on the rocks / where I sit." It recurs in one of the later poems, "The Chinese Poet Sits on His Favorite Rock Above the River and Welcomes the Herons Back After a Long Winter," in which we identify the returning herons as the resurgence of poetic inspiration after an unproductive spell:

Spirits of air, of water, of beloved place,
of generations passing,
I lift my hand like a wing
and my spirit rises
to join you!

There are other symbols throughout *Chinese Poet* that serve these unifying thematic functions, and most of them are traditional in Chinese verse: the letter that remains to be written, the glass of wine, dinner with friends, the beard that signifies wisdom and the tolerant humor of age, the act of writing. They are all brilliantly adapted into the Appalachian setting and cast suggestive lights and shadows on our own tradition.



Stephen Marion, courtesy of Marianne Worthington

Jeff Daniel Marion

The symbolic image that dominates the fourth and final section of poems is wonderfully apt for both the Appalachian and the Chinese attitudes of the book. Marion chooses the mountain as a symbol for retreat, for meditation, for the journey to the world beyond, for retirement, for farewell.

In these poems, the themes that occupied the earlier sections — friendship, literature, love of nature, experience — are bade a peaceable good-bye. Those moods of yearning, of gentle regret, of insistent wistfulness give way to what I can only call a calm but poignant benediction.

I had read in journals over the years different poems from this collection but could not form the faintest conception of what its effect would be as a whole. *The Chinese Poet Awakens* is a subtle book but no less forceful because of that. One puts it down with a sigh of regret and takes it up again with a smile of acceptance:

O friends, do not look for me on your journey.
I am neither in the words
nor between the words, but in the mist
rising over the mountain.

— Fred Chappell

Fred Chappell's new book of poems, Family Gathering, *will be published by Louisiana State University Press, autumn 2000.*

Lessons In Hunger

I

Which life is this?
Burned-out in Brooklyn
and my fist is broken again,
the fourth time in a dozen years.
These rituals of the emergency room
are easy to learn, full of spice
or suffering from exhaustion.
But this is new.
The doctor speaks no English.
He tells me at 4 a.m., *seet dun heer,*
patting the door with his eager hands.
Beside the boggy red mattress
blood half-fills a beaker.
A silken spray juts across
the ribbed ceiling.
I decide to wait in the hall.
The doctor hands spike at me,
Be still, be still, ah shit.
The bugs busy themselves in the wall.

II

Once before I was born,
my mother tried to kill herself,
because my father was going
to leave her.
She rolled out of the moving car
and bounced like a bad apple
on the blacktop.
For two weeks she could not speak,
scorched by rejection,
spitting asphalt into her mint tea
through the cloud of mentholatum.
My father sat in the corner
like an old boot
and croaked for a foot.
My mother's yes
was the first word uttered
and made the marrying simple.
In her dimples, my father
turned to wine.
They rubbed the black stone together.

III

In the thirty-six years
that I've known my father,
I've only seen him cry three times.
The first time I was ten
and George Foreman
was pummeling Joe Frazier,
knocked him down six times
in two rounds.
The last was a straight right hand
to the back of Joe's skull,
thrown as he had turned to run,
spasmodically attempting to escape.
He spilled down
like a bowl of jelly,
the fearless eyes frozen
black in the camera.
My father cried, lifted his hand
to hide and I cried too,
because he had,
because in the mad dramatic
clatter of wills I had just
witnessed, something awful
had broken and broken him.
He cradled his beer with both hands
and looked out the window
a long time and there we sat
in that enormous room,
quiet together.

IV

My grandmother died raving mad,
with a tumor the size of a baseball
spreading its fingers in her brain.
I was twenty-eight, a rock and roll gypsy,
naive beyond belief.
My father's voice
had already begun to break
when he summoned me from the road.
My grandmother had fallen
unconscious in the barn,
face down in a swamp of cow shit.

For fifty years she had been
the plow that pulled my grandfather
through his life, birthing three sons
on the kitchen table
and cutting the cord herself.
At 4 a.m. for fifty years
she would rise, pull the eggs
from beneath the chickens
and milk every cow.
My grandfather was up at six,
straight to his plate

of biscuits and bacon strips.
When he ate I never heard him speak.

My grandmother didn't know a soul
when she died, there wasn't
a face she could recognize.
The baby in her womb
was covered in fur, she said.
Moths were flying in her chest,
spreading their wings in her head.
She crawled on all fours
and hid in the closet,
ate the lint from beneath her bed.

When she died, my father and I
were on opposite sides,
each of us held a hand.
The room was filled
with her last sigh,
like a lily that breaks on the water
in a sudden bubble
and then the long horrid whine
of hospital machinery
with nothing left to do.
No, my father said, and fell
to his knees trembling and crying
in a lost sea, washed like a crab
from a rock, swimming in midair
through white static.
Boys help, he said,
as the doctors and the family
crashed into the room,
each more frantic than the other.

My father and I handle crisis
the same, we have to be alone.
I watched him the rest of the night,
huddled in the darkness
with the eyes of a mountain,
as the small humiliations piled up,
the taboos of the bathroom,
the silence of the kitchen table,
the endless aphasia
like a cage against love.
I don't know who you are,
he said to me.
I don't know what happened to the time.
My father slept through my childhood
in a trance on the couch,
an exile in his own house.

I drifted upon the rickety fire escape
and traced with my fingertip
the imagined outline
of my grandmother's spirit,
like a dusty bee bumping across
the alley, creeping to the outskirts
of the hospital, her golden figure
reflected in seven empty windows,
in a building set next to nothing.
A mall once, a tackle shop
behind bars, a haberdashery
with a giant velvet glove
painted on the door, waving
as my grandmother passed over,
like a wind trail on the water,
and then the wrinkles are gone.

V

I'm home now, like Frost,
the place where,
when you have to go there,
they have to take you in.
My father has stopped drinking.
His second attempt in thirty-five years.
He descends the stairs, shaking so bad
that he begs me for a joint.
But I'm penniless, with a broken fist,
so I have to stay sober.
And I realize that my father
has been drunk his whole life
for the same reason.

I light his cigarette instead.

—Keith Flynn

Keith Flynn, founder and managing editor of The Asheville Poetry Review, *studied at Mars Hill College and the University of North Carolina-Asheville, winning the Sandburg Prize in 1985. He is lyricist and lead singer for the nationally acclaimed rock band, The Crystal Zoo, which has a third album about to be released. He is author of three collections of poetry,* The Talking Drum, The Book of Monsters, *and* The Lost Sea. *Flynn is a member of The Academy of American Poets.*

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Courtesy of Alice Sink and Bett Hudson Eatman

Your Dimes Bought This Iron Lung
A nurse and polio patient in Western North Carolina do their best to raise funds for the March of Dimes. In "The Grit Behind the Miracle," (p.8) Alice E. Sink describes how the citizens of Hickory, N.C. banded together to build an emergency polio hospital almost overnight.

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